

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/28/2020 9:20 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/28/2020	Time: 9:20 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANNIBAL REGIONAL HOSPITAL (26-0025) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) ROB GASAWAY

Officer or Administrator of Provider(s)

VICE PRESIDENT FINANCE/CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-267,169	1,849	0	1,692,639	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	5,184	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		14,402		0	10.00
10.01	RURAL HEALTH CLINIC II	0		26,873		0	10.01
10.02	RURAL HEALTH CLINIC III	0		41,958		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		37,604		0	10.03
10.04	RURAL HEALTH CLINIC V	0		36,617		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		297		0	10.05
10.06	RURAL HEALTH CLINIC VII	0		2,255		0	10.06
10.07	RURAL HEALTH CLINIC VIII	0		743		0	10.07
10.08	RURAL HEALTH CLINIC IX	0		73,537		0	10.08
10.09	RURAL HEALTH CLINIC X	0		6,462		0	10.09
200.00	Total	0	-261,985	242,597	0	1,692,639	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 26-0025		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 9:20 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: HIGHWAY 36, 6000 HOSPITAL DRIVE			PO Box:				1.00		
2.00	City: HANNIBAL			State: MO		Zip Code: 63401		County: MARION		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		HANNIBAL REGIONAL HOSPITAL	260025	99926	1	01/01/1966	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF		HANNIBAL REGIONAL HOSPITAL	26T025	99926	5	10/01/2015	N	P	O
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		HANNIBAL REGIONAL - HHA	267282	99926		04/10/1990	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		HANNIBAL REG - SHELBYNA	268512	99926		06/11/1997	N	O	O
15.01	Hospital-Based Health Clinic - RHC		HANNIBAL REG - LAGRANGE	263984	99926		04/03/1992	N	O	O
15.02	Hospital-Based Health Clinic - RHC		HANNIBAL REG - MONROE CITY	268513	99926		06/11/1997	N	O	O
15.03	Hospital-Based Health Clinic - RHC		HANNIBAL REG - LOUISIANA	268723	99926		04/01/2014	N	O	O
15.04	Hospital-Based Health Clinic - RHC		HANNIBAL REG - BOWLING GREEN	268724	99926		04/01/2014	N	O	O
15.05	Hospital-Based Health Clinic - RHC		HANNIBAL REG - LA PLATA	268756	99926		07/03/2017	N	O	O
15.06	Hospital-Based Health Clinic - RHC		HANNIBAL REG - LANCASTER	268757	99926		07/03/2017	N	O	O
15.07	Hospital-Based Health Clinic - RHC		HANNIBAL REG - KIRKSVILLE	268758	99926		07/03/2017	N	O	O
15.08	Hospital-Based Health Clinic - RHC		HANNIBAL REG - HRMG 2ND FLOOR	268754	99926		07/24/2017	N	O	O
15.09	Hospital-Based Health Clinic - RHC		HANNIBAL REG - WALMART	268759	99926		11/07/2017	N	O	O
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018	09/30/2019		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0025		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 9:20 am	
		1.00	2.00	3.00			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N			23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
		1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,190	0	57	0	1,019	0
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0
		Urban/Rural S				Date of Geogr	
		1.00				2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1				35.00	
		Beginning:				Ending:	
		1.00				2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2018				09/30/2019	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N				Y/N	
		1.00				2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N				N	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N				N	
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N				N	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N				N	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N				N	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N				N	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N					
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N					
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0025		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 9:20 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/28/2020 9:20 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
			1.00	2.00	3.00			
70.00	Inpatient Psychiatric Facility PPS							
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00		
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00	
	Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	76.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 9:20 am				
			1.00					
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.06		
Rural Providers								
105.00	Does this hospital qualify as a CAH?			N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.					107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N	109.00
			1.00					
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 9:20 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	396,844	122,000		0 118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/28/2020 9:20 am

1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	
						2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00
						1.00	
						2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)				N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/28/2020 9:20 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/18/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/03/2020	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/28/2020 9:20 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/28/2020 9:20 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	78	28,470	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		78	28,470	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		86	31,390	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	13	4,745		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
26.05 RURAL HEALTH CLINIC VI	88.05				0	26.05
26.06 RURAL HEALTH CLINIC VII	88.06				0	26.06
26.07 RURAL HEALTH CLINIC VIII	88.07				0	26.07
26.08 RURAL HEALTH CLINIC IX	88.08				0	26.08
26.09 RURAL HEALTH CLINIC X	88.09				0	26.09
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		99				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,681	970	13,426			1.00
2.00	HMO and other (see instructions)	1,596	1,019				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	101	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,681	970	13,426			7.00
8.00	INTENSIVE CARE UNIT	993	166	1,777			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		98	1,164			13.00
14.00	Total (see instructions)	8,674	1,234	16,367	0.00	906.05	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,125	0	2,871	0.00	16.70	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	6,434	356	10,176	0.00	19.07	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,235	111	4,812	0.00	7.98	26.00
26.01	RURAL HEALTH CLINIC II	770	43	2,732	0.00	5.25	26.01
26.02	RURAL HEALTH CLINIC III	1,285	226	4,246	0.00	8.43	26.02
26.03	RURAL HEALTH CLINIC IV	1,634	284	4,942	0.00	10.24	26.03
26.04	RURAL HEALTH CLINIC V	2,081	445	11,975	0.00	15.39	26.04
26.05	RURAL HEALTH CLINIC VI	258	70	1,066	0.00	1.60	26.05
26.06	RURAL HEALTH CLINIC VII	1,099	87	3,215	0.00	4.33	26.06
26.07	RURAL HEALTH CLINIC VIII	499	121	2,428	0.00	2.59	26.07
26.08	RURAL HEALTH CLINIC IX	4,269	974	19,373	0.00	34.17	26.08
26.09	RURAL HEALTH CLINIC X	291	107	4,364	0.00	5.17	26.09
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,036.97	27.00
28.00	Observation Bed Days		0	1,041			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	13	174			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,157	343	4,534	1.00
2.00 HMO and other (see instructions)			382	286		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,157	343	4,534	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	193	0	260	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.04 RURAL HEALTH CLINIC V	0.00					26.04
26.05 RURAL HEALTH CLINIC VI	0.00					26.05
26.06 RURAL HEALTH CLINIC VII	0.00					26.06
26.07 RURAL HEALTH CLINIC VIII	0.00					26.07
26.08 RURAL HEALTH CLINIC IX	0.00					26.08
26.09 RURAL HEALTH CLINIC X	0.00					26.09
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/28/2020 9:20 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	77,558,322	0	77,558,322	2,156,891.00	35.96	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		306,730	0	306,730	2,168.68	141.44	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		10,205,316	0	10,205,316	59,538.13	171.41	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,502,813	0	2,502,813	165,457.74	15.13	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		21,340,541	-510,445	20,830,096	374,250.34	55.66	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,204,533	0	1,204,533	16,497.89	73.01	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		405,321	0	405,321	1,782.41	227.40	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,542,372	0	14,542,372			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		4,365,886	0	4,365,886			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		48,170	0	48,170			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,463,687	0	1,463,687			23.00
24.00	Wage-related costs (RHC/FQHC)		1,185,488	0	1,185,488			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	538,347	313,053	851,400	41,516.35	20.51	26.00
27.00	Administrative & General	5.00	13,568,792	146,151	13,714,943	439,258.10	31.22	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/28/2020 9:20 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		852,812	0	852,812	3,259.08	261.67	28.00
29.00	Maintenance & Repairs	6.00	466,928	0	466,928	28,332.00	16.48	29.00
30.00	Operation of Plant	7.00	900,383	0	900,383	40,714.00	22.11	30.00
31.00	Laundry & Linen Service	8.00	28,465	0	28,465	2,855.00	9.97	31.00
32.00	Housekeeping	9.00	719,497	0	719,497	54,903.00	13.10	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,036,440	0	1,036,440	61,029.00	16.98	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,124,024	0	1,124,024	31,550.00	35.63	38.00
39.00	Central Services and Supply	14.00	184,081	0	184,081	10,138.00	18.16	39.00
40.00	Pharmacy	15.00	1,747,854	-1,747,854	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	796,152	0	796,152	35,643.00	22.34	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/28/2020 9:20 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	65,703,005	0	65,703,005	1,935,154.21	33.95	1.00
2.00	Excluded area salaries (see instructions)	21,340,541	-510,445	20,830,096	374,250.34	55.66	2.00
3.00	Subtotal salaries (line 1 minus line 2)	44,362,464	510,445	44,872,909	1,560,903.87	28.75	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,609,854	0	1,609,854	18,280.30	88.06	4.00
5.00	Subtotal wage-related costs (see inst.)	14,590,542	0	14,590,542	0.00	32.52	5.00
6.00	Total (sum of lines 3 thru 5)	60,562,860	510,445	61,073,305	1,579,184.17	38.67	6.00
7.00	Total overhead cost (see instructions)	21,963,775	-1,288,650	20,675,125	749,197.53	27.60	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 2/28/2020 9:20 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		2,743,080	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		985,931	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		346,410	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		11,495,507	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		-24,475	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		81,531	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		231,579	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		636,882	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		4,803,773	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		19,387	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		200,288	21.00
22.00	Day Care Cost and Allowances		76,712	22.00
23.00	Tuition Reimbursement		8,998	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		21,605,603	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part V
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,204,533	21,605,603	1.00
2.00	Hospital	1,204,533	21,605,603	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
14.06	Hospital-Based Health Clinic RHC 6	0	0	14.06
14.07	Hospital-Based Health Clinic RHC 7	0	0	14.07
14.08	Hospital-Based Health Clinic RHC 8	0	0	14.08
14.09	Hospital-Based Health Clinic RHC 9	0	0	14.09
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 26-0025 Component CCN: 26-7282		Period: From 10/01/2018 To 09/30/2019	
				Home Health Agency I		Worksheet S-4 Date/Time Prepared: 2/28/2020 9:20 am	
						PPS	
				1.00			
0.00 County				MARION		0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
				Total		5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,173	0	476	1,649	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	389.00	36.00	218.00	643.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			3.00	0.00	3.00	5.00
6.00	Direct Nursing Service			9.00	0.00	9.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			3.00	0.00	3.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.00	0.00	2.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.00	0.00	1.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
20.01				99926			20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,493	261	74	63	2,891	21.00
22.00	Skilled Nursing Visit Charges	548,460	57,420	16,280	13,860	636,020	22.00
23.00	Physical Therapy Visits	1,775	188	12	40	2,015	23.00
24.00	Physical Therapy Visit Charges	399,150	42,300	2,700	9,000	453,150	24.00
25.00	Occupational Therapy Visits	786	181	4	2	973	25.00
26.00	Occupational Therapy Visit Charges	176,850	40,725	900	450	218,925	26.00
27.00	Speech Pathology Visits	59	23	0	0	82	27.00
28.00	Speech Pathology Visit Charges	13,275	5,175	0	0	18,450	28.00
29.00	Medical Social Service Visits	19	3	0	0	22	29.00
30.00	Medical Social Service Visit Charges	4,275	675	0	0	4,950	30.00
31.00	Home Health Aide Visits	372	60	1	18	451	31.00
32.00	Home Health Aide Visit Charges	44,640	7,200	120	2,160	54,120	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,504	716	91	123	6,434	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,186,650	153,495	20,000	25,470	1,385,615	35.00
36.00	Total Number of Episodes (standard/non outlier)	376		34	7	417	36.00
37.00	Total Number of Outlier Episodes		18		2	20	37.00
38.00	Total Non-Routine Medical Supply Charges	23,960	5,344	1,060	542	30,906	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 26-0025
 Component CCN: 26-8512

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet S-8
 Date/Time Prepared:
 2/28/2020 9:20 am

				RHC I		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			400 S. CENTER STREET		1.00	
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			SHELBY		MO 63468 2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00	
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
			Sunday		Monday		Tuesday
			from	to	from	to	from
			1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)							
11.00	CLINIC			08:00		17:00 08:00 11.00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
			Y/N	V	XVIII	XIX	Total Visits
			1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
				County			
				4.00			
2.00	City, State, ZIP Code, County			SHELBY		2.00	
			Tuesday	Wednesday		Thursday	
			to	from	to	from	to
			6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)							
11.00	CLINIC			17:00	08:00	17:00	08:00 17:00 11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025	Period: From 10/01/2018	Worksheet S-8
			Component CCN: 26-8512	To 09/30/2019	Date/Time Prepared: 2/28/2020 9:20 am
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-3984		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC II		Cost	
		1.00			
Clinic Address and Identification		1802 ELM STREET		1.00	
1.00	Street	City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CANTON	MO	63435	2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00	08:00	11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	LEWIS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025 Component CCN: 26-3984	Period: From 10/01/2018 To 09/30/2019	Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am	
			RHC II		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8513		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	821 BUSINESS HWYS 24 & 36		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MONROE CITY		MO 63456 2.00	
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
				Tuesday	
				from	
				5.00	
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00 08:00 11.00	
				1.00 2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	MONROE		2.00	
		Tuesday	Wednesday	Thursday	
		to	from to	from to	
		6.00	7.00 8.00	9.00 10.00	
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00 17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8513

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

RHC III

Cost

		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)							
	CLINIC	08:00	17:00				11.00	

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025 Component CCN: 26-8723		Period: From 10/01/2018 To 09/30/2019
			Worksheet S-8		Date/Time Prepared: 2/28/2020 9:20 am
			RHC IV		Cost
			1.00		
Clinic Address and Identification					
1.00	Street		211 SOUTH 3RD STREET		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		LOUISIANA MO 63353		2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		5.00			
Facility hours of operations (1)					
11.00	CLINIC		08:00	17:00	08:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
			County		
			4.00		
2.00	City, State, ZIP Code, County		PIKE		2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC		17:00	08:00	17:00
			08:00		17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8723

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

RHC IV

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	08:00	17:00				11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8724		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC V		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	905 HWY 161		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	BOWLING GREEN		MO 63334 2.00	
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
				Tuesday	
				from	
				5.00	
Facility hours of operations (1)					
11.00	CLINIC	07:00	17:00	07:00	19:00
				1.00	
				2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	PIKE		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
				10.00	
Facility hours of operations (1)					
11.00	CLINIC	19:00	07:00	19:00	07:00
				19:00	
				11.00	

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025	Period: From 10/01/2018	Worksheet S-8
			Component CCN: 26-8724	To 09/30/2019	Date/Time Prepared: 2/28/2020 9:20 am
			RHC V		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	07:00	19:00	07:00	17:00
					11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8756		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC VI		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	29934 JULY ROAD		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	LA PLATA		MO 63549 2.00	
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
				Tuesday	
				from	
				5.00	
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00 08:00 11.00	
				1.00 2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	MACON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from to	from to	
		6.00	7.00 8.00	9.00 10.00	
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00 17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 26-0025 Component CCN: 26-8756		Period: From 10/01/2018 To 09/30/2019		Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am	
						RHC VI		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			08:00	17:00				11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025 Component CCN: 26-8757		Period: From 10/01/2018 To 09/30/2019
			Worksheet S-8		Date/Time Prepared: 2/28/2020 9:20 am
			RHC VII		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street			1000 WEST WASHINGTON STREET	1.00
	City			State	ZIP Code
	1.00			2.00	3.00
2.00	City, State, ZIP Code, County			LANCASTER	MO 63548
			1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0
			Sunday		Monday
			from	to	from
			1.00	2.00	3.00
			Tuesday		from
			1.00		2.00
11.00	Facility hours of operations (1)				
	CLINIC			08:00	17:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?			N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
			Y/N		V
			1.00		2.00
			XVIII		XIX
			3.00		4.00
			Total Visits		5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
			County		4.00
2.00	City, State, ZIP Code, County			SCHUYLER	
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
			Thursday		from
			to		10.00
11.00	Facility hours of operations (1)				
	CLINIC			17:00	08:00
				17:00	08:00
				17:00	11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025	Period: From 10/01/2018	Worksheet S-8
			Component CCN: 26-8757	To 09/30/2019	Date/Time Prepared: 2/28/2020 9:20 am
			RHC VII		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8758		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC VIII		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1611 SOUTH BALTIMORE STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KIRKSVILLE		MO 63501 2.00	
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
				Tuesday	
				from	
				5.00	
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00 08:00 11.00	
				1.00 2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	ADAIR		2.00	
		Tuesday	Wednesday	Thursday	
		to	from to	from to	
		6.00	7.00 8.00	9.00 10.00	
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00 17:00 11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025	Period: From 10/01/2018	Worksheet S-8
			Component CCN: 26-8758	To 09/30/2019	Date/Time Prepared: 2/28/2020 9:20 am
			RHC VIII		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8754		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC IX		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	6500 HOSPITAL DRIVE			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	HANNIBAL MO 63401			2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0			3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N 0			10.00
		Sunday		Monday	Tuesday
		from	to	from	from
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N 0			13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
					Total Visits
					5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County			
		4.00			
2.00	City, State, ZIP Code, County	RALLS			2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
					10.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8754

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

RHC IX

Cost

		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)							
	CLINIC	08:00	17:00				11.00	

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8759		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/28/2020 9:20 am		
		RHC X		Cost		
		1.00				
1.00	Clinic Address and Identification	3650 STARDUST DRIVE				1.00
	Street					
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	HANNIBAL		MO 63401		2.00
				1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00
		Grant Award		Date		
		1.00		2.00		
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC	11:00	18:00	08:00	20:00	08:00
		1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County	MARION				2.00
		Tuesday	Wednesday	Thursday		
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
	Facility hours of operations (1)					
11.00	CLINIC	20:00	08:00	20:00	08:00	20:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8759

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

RHC X

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	20:00	08:00	19:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-10

Date/Time Prepared:
2/28/2020 9:20 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.288612	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		7,449,053	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		44,940,958	6.00
7.00	Medicaid cost (line 1 times line 6)		12,970,500	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		5,521,447	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		5,521,447	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	7,107,232	4,179,198	11,286,430
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,051,232	4,179,198	6,230,430
22.00	Payments received from patients for amounts previously written off as charity care	34,702	3,556	38,258
23.00	Cost of charity care (line 21 minus line 22)	2,016,530	4,175,642	6,192,172
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		16,463,760	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		519,534	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		799,282	27.01
28.00	Non-Medicare bad debt expense (see instructions)		15,664,478	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,800,704	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		10,992,876	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		16,514,323	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,355,547	3,355,547	68,123	3,423,670
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,620,860	4,620,860	-1,329,587	3,291,273
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	538,347	13,303,976	13,842,323	389,765	14,232,088
5.00	00500	ADMINISTRATIVE & GENERAL	13,568,792	11,627,503	25,196,295	29,249	25,225,544
6.00	00600	MAINTENANCE & REPAIRS	466,928	73,658	540,586	0	540,586
7.00	00700	OPERATION OF PLANT	900,383	3,053,572	3,953,955	-348,304	3,605,651
8.00	00800	LAUNDRY & LINEN SERVICE	28,465	304,318	332,783	0	332,783
9.00	00900	HOUSEKEEPING	719,497	176,912	896,409	348,304	1,244,713
10.00	01000	DIETARY	1,036,440	889,533	1,925,973	0	1,925,973
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,124,024	309,158	1,433,182	152,034	1,585,216
14.00	01400	CENTRAL SERVICES & SUPPLY	184,081	164,005	348,086	0	348,086
15.00	01500	PHARMACY	1,747,854	711,962	2,459,816	-1,747,854	711,962
16.00	01600	MEDICAL RECORDS & LIBRARY	796,152	1,127,442	1,923,594	0	1,923,594
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,978,962	5,049,762	13,028,724	-25,725	13,002,999
31.00	03100	INTENSIVE CARE UNIT	1,767,460	352,034	2,119,494	0	2,119,494
41.00	04100	SUBPROVIDER - IRF	1,087,451	1,179,560	2,267,011	0	2,267,011
43.00	04300	NURSERY	261,210	140,141	401,351	0	401,351
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,681,540	1,658,013	3,339,553	0	3,339,553
51.00	05100	RECOVERY ROOM	1,094,705	176,657	1,271,362	0	1,271,362
52.00	05200	DELIVERY ROOM & LABOR ROOM	794,690	247,781	1,042,471	0	1,042,471
53.00	05300	ANESTHESIOLOGY	2,053,979	673,208	2,727,187	0	2,727,187
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,377,767	1,080,935	2,458,702	347,987	2,806,689
55.00	05500	RADIOLOGY - THERAPEUTIC	790,879	686,143	1,477,022	127,460	1,604,482
56.00	05600	RADIOISOTOPE	115,894	135,288	251,182	329,277	580,459
57.00	05700	CT SCAN	305,255	246,122	551,377	206,286	757,663
58.00	05800	MRI	131,343	159,870	291,213	158,388	449,601
59.00	05900	CARDIAC CATHETERIZATION	662,083	1,816,867	2,478,950	0	2,478,950
60.00	06000	LABORATORY	2,445,241	2,742,914	5,188,155	27,554	5,215,709
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	121,787	465,195	586,982	0	586,982
64.00	06400	INTRAVENOUS THERAPY	515,698	94,356	610,054	0	610,054
65.00	06500	RESPIRATORY THERAPY	873,910	275,652	1,149,562	0	1,149,562
66.00	06600	PHYSICAL THERAPY	522,226	876,236	1,398,462	0	1,398,462
67.00	06700	OCCUPATIONAL THERAPY	63,019	560,903	623,922	0	623,922
68.00	06800	SPEECH PATHOLOGY	222,350	49,974	272,324	0	272,324
69.00	06900	ELECTROCARDIOLOGY	70,996	38,212	109,208	0	109,208
70.00	07000	ELECTROENCEPHALOGRAPHY	174,836	42,481	217,317	0	217,317
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,218,137	3,218,137	4,642,332	7,860,469
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,801,419	8,801,419	-4,642,332	4,159,087
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,316,088	8,316,088	1,747,854	10,063,942
74.00	07400	RENAL DIALYSIS	0	103,931	103,931	0	103,931
76.00	03950	DIABETES CENTER	94,579	14,828	109,407	0	109,407
76.97	07697	CARDIAC REHABILITATION	180,703	27,253	207,956	0	207,956
76.98	07698	HYPERBARIC OXYGEN THERAPY	97,107	15,953	113,060	0	113,060
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	581,480	176,630	758,110	0	758,110
88.01	08801	RURAL HEALTH CLINIC II	326,249	187,206	513,455	29,380	542,835
88.02	08802	RURAL HEALTH CLINIC III	500,095	186,940	687,035	0	687,035
88.03	08803	RURAL HEALTH CLINIC IV	1,124,490	386,947	1,511,437	-616,165	895,272
88.04	08804	RURAL HEALTH CLINIC V	1,065,250	522,812	1,588,062	616,165	2,204,227
88.05	08805	RURAL HEALTH CLINIC VI	103,667	50,429	154,096	0	154,096
88.06	08806	RURAL HEALTH CLINIC VII	255,445	87,632	343,077	0	343,077
88.07	08807	RURAL HEALTH CLINIC VIII	171,976	24,124	196,100	0	196,100
88.08	08808	RURAL HEALTH CLINIC IX	3,915,377	957,266	4,872,643	-1,269	4,871,374
88.09	08809	RURAL HEALTH CLINIC X	297,811	87,820	385,631	78,235	463,866
91.00	09100	EMERGENCY	2,366,759	5,304,018	7,670,777	0	7,670,777
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,306,599	316,199	1,622,798	0	1,622,798
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		801,697	801,697	0	801,697
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,611,831	88,054,079	146,665,910	587,157	147,253,067
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,042,905	4,708,672	22,751,577	-197,392	22,554,185
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0
194.01	07951	CHILD DEVELOPMENT CENTER	903,586	221,418	1,125,004	-389,765	735,239
194.02	07952	HWY 61 BUILDING	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)	77,558,322	92,984,169	170,542,491	0	170,542,491

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-157,301	3,266,369	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,812	3,285,461	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	155,689	14,387,777	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,633,700	27,859,244	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	540,586	6.00
7.00	00700	OPERATION OF PLANT	-9,006	3,596,645	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	332,783	8.00
9.00	00900	HOUSEKEEPING	0	1,244,713	9.00
10.00	01000	DIETARY	-711,922	1,214,051	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,585,216	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	348,086	14.00
15.00	01500	PHARMACY	0	711,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-17,747	1,905,847	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,894,433	9,108,566	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,119,494	31.00
41.00	04100	SUBPROVIDER - IRF	-114,046	2,152,965	41.00
43.00	04300	NURSERY	0	401,351	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-552,743	2,786,810	50.00
51.00	05100	RECOVERY ROOM	0	1,271,362	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-96	1,042,375	52.00
53.00	05300	ANESTHESIOLOGY	-2,483,093	244,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,068	2,805,621	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,604,482	55.00
56.00	05600	RADIOISOTOPE	0	580,459	56.00
57.00	05700	CT SCAN	0	757,663	57.00
58.00	05800	MRI	0	449,601	58.00
59.00	05900	CARDIAC CATHETERIZATION	-1,293,398	1,185,552	59.00
60.00	06000	LABORATORY	-827,113	4,388,596	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	586,982	62.00
64.00	06400	INTRAVENOUS THERAPY	0	610,054	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,149,562	65.00
66.00	06600	PHYSICAL THERAPY	0	1,398,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	623,922	67.00
68.00	06800	SPEECH PATHOLOGY	0	272,324	68.00
69.00	06900	ELECTROCARDIOLOGY	0	109,208	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	217,317	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,860,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,159,087	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,063,942	73.00
74.00	07400	RENAL DIALYSIS	0	103,931	74.00
76.00	03950	DIABETES CENTER	0	109,407	76.00
76.97	07697	CARDIAC REHABILITATION	0	207,956	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	113,060	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	758,110	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	542,835	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	687,035	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	895,272	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,204,227	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	154,096	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	343,077	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	196,100	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	4,871,374	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	463,866	88.09
91.00	09100	EMERGENCY	-4,634,275	3,036,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,622,798	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-801,697	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,714,361	134,538,706	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,554,185	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	735,239	194.01
194.02	07952	HWY 61 BUILDING	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,714,361	157,828,130	200.00

RECLASSIFICATIONS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/28/2020 9:20 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	C - CAPITAL LEASE EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,491		1.00
2.00	NURSING ADMINISTRATION	13.00	0	152,034		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	347,987		3.00
4.00	RADIOLOGY - THERAPEUTIC	55.00	0	127,460		4.00
5.00	RADIOISOTOPE	56.00	0	329,277		5.00
6.00	CT SCAN	57.00	0	206,286		6.00
7.00	MRI	58.00	0	158,388		7.00
8.00	LABORATORY	60.00	0	27,554		8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	29,380		9.00
			0	1,391,857		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	130,393		1.00
			0	130,393		
	E - IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,642,332		1.00
			0	4,642,332		
	F - CHILDREN'S CENTER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	313,053	76,712		1.00
			313,053	76,712		
	G - OUTSIDE CLEANING SERVICE					
1.00	HOUSEKEEPING	9.00	0	348,304		1.00
			0	348,304		
	H - PHARMACY SALARIES					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,747,854	0		1.00
			1,747,854	0		
	I - MEDICAL DIRECTORSHIPS					
1.00	ADMINISTRATIVE & GENERAL	5.00	146,151	0		1.00
2.00		0.00	0	0		2.00
			146,151	0		
	J - RHC SALARIES					
1.00	RURAL HEALTH CLINIC X	88.09	78,235	0		1.00
2.00		0.00	0	0		2.00
			78,235	0		
	K - BOWLING GREEN & LOUISIANA CLINICS					
1.00	RURAL HEALTH CLINIC V	88.04	557,557	58,608		1.00
			557,557	58,608		
500.00	Grand Total: Increases		2,842,850	6,648,206		500.00

RECLASSIFICATIONS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/28/2020 9:20 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	C - CAPITAL LEASE EXP						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,391,857	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		0	1,391,857			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	130,393	5		1.00
	0		0	130,393			
	E - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,642,332	0		1.00
	0		0	4,642,332			
	F - CHILDREN'S CENTER						
1.00	CHILD DEVELOPMENT CENTER	194.01	313,053	76,712	0		1.00
	0		313,053	76,712			
	G - OUTSIDE CLEANING SERVICE						
1.00	OPERATION OF PLANT	7.00	0	348,304	0		1.00
	0		0	348,304			
	H - PHARMACY SALARIES						
1.00	PHARMACY	15.00	1,747,854	0	0		1.00
	0		1,747,854	0			
	I - MEDICAL DIRECTORSHIPS						
1.00	ADULTS & PEDIATRICS	30.00	25,725	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	120,426	0	0		2.00
	0		146,151	0			
	J - RHC SALARIES						
1.00	RURAL HEALTH CLINIC IX	88.08	1,269	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	76,966	0	0		2.00
	0		78,235	0			
	K - BOWLING GREEN & LOUISIANA CLINICS						
1.00	RURAL HEALTH CLINIC IV	88.03	557,557	58,608	0		1.00
	0		557,557	58,608			
500.00	Grand Total: Decreases		2,842,850	6,648,206			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/28/2020 9:20 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,479,295	1,236,461	0	1,236,461	3,500	1.00	
2.00	Land Improvements	8,818,856	716,596	0	716,596	412,274	2.00	
3.00	Buildings and Fixtures	68,059,331	15,860,664	0	15,860,664	2,575,937	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	1,544,761	21,642,645	0	21,642,645	104,183	5.00	
6.00	Movable Equipment	75,232,280	9,749,286	0	9,749,286	12,487,311	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	156,134,523	49,205,652	0	49,205,652	15,583,205	8.00	
9.00	Reconciling Items	-22,617,870	-21,272,622	0	-21,272,622	-40,574,153	9.00	
10.00	Total (line 8 minus line 9)	178,752,393	70,478,274	0	70,478,274	56,157,358	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	3,712,256	0					1.00
2.00	Land Improvements	9,123,178	0					
3.00	Buildings and Fixtures	81,344,058	0					
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	23,083,223	0					
6.00	Movable Equipment	72,494,255	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	189,756,970	0					
9.00	Reconciling Items	-3,316,339	0					
10.00	Total (line 8 minus line 9)	193,073,309	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,427,443	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,620,860	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,048,303	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	-71,896	3,355,547				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,620,860				2.00
3.00	Total (sum of lines 1-2)	-71,896	7,976,407				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	94,179,492	0	94,179,492	0.522443	68,123	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,577,478	9,489,624	86,087,854	0.477557	62,270	2.00
3.00	Total (sum of lines 1-2)	189,756,970	9,489,624	180,267,346	1.000000	130,393	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	68,123	3,270,142	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	62,270	3,223,191	0	2.00
3.00	Total (sum of lines 1-2)	0	0	130,393	6,493,333	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	68,123	0	-71,896	3,266,369	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	62,270	0	0	3,285,461	2.00
3.00	Total (sum of lines 1-2)	0	130,393	0	-71,896	6,551,830	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-801,697	INTEREST EXPENSE	113.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,006	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-14,027,665			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-711,922	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-17,747	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-1,300,658	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/28/2020 9:20 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.00 NON ALLOWED ADVERTISING COSTS	A	-1,523,078	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01 ADVERTISING EMPLOYEE BENEFITS	A	-30,549	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
35.00 LOBBYING EXPENSE	A	-18,854	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 ALCOHOLIC BEVERAGE EXPENSE	A	-1,698	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 DEVELOPMENT SALARIES	A	-115,342	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01 DEVELOPMENT EXPENSE	A	-120,617	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.02 FOUNDATION EMPLOYEE BENEFITS	A	-12,950	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.02
38.00 DEFINED BENEFIT PENSION PLAN	A	985,931	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00 CONTRIBUTIONS	A	-52,328	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01 RECRUITMENT FEES	A	-525,072	ADMINISTRATIVE & GENERAL	5.00	0	39.01
39.02 RECRUITMENT FEES	A	-23,715	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.02
39.03 PATIENT PHONE	A	-25,912	ADMINISTRATIVE & GENERAL	5.00	0	39.03
39.04 PATIENT PHONE	A	-5,812	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.04
39.05 DAYCARE REVENUE	B	-267,328	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.05
40.00 MEDICAID/FRA	A	6,711,564	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00 EMPLOYED PHYSICIAN BENEFITS	A	-495,700	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
45.03 BUILDING RENTAL INCOME	B	-157,301	CAP REL COSTS-BLDG & FIXT	1.00	9	45.03
45.10 PHYSICIAN PENSION EXPENSE	A	-2,613	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11 PHYSICIAN PENSION EXPENSE	A	-54,741	ADULTS & PEDIATRICS	30.00	0	45.11
45.13 PHYSICIAN PENSION EXPENSE	A	-3,644	SUBPROVIDER - IRF	41.00	0	45.13
45.14 PHYSICIAN PENSION EXPENSE	A	-1,181	OPERATING ROOM	50.00	0	45.14
45.15 PHYSICIAN PENSION EXPENSE	A	-78,194	ANESTHESIOLOGY	53.00	0	45.15
45.17 PHYSICIAN PENSION EXPENSE	A	-22,393	LABORATORY	60.00	0	45.17
45.18 PHYSICIAN PENSION EXPENSE	A	-4,139	EMERGENCY	91.00	0	45.18
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,714,361				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/28/2020 9:20 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	716,568	160,930	555,638	211,500	3,195	1.00
2.00	30.00	ADULTS & PEDIATRICS	3,839,692	3,839,692	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	110,402	110,402	0	0	0	3.00
4.00	50.00	OPERATING ROOM	551,562	551,562	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	96	96	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,424,797	2,394,384	30,413	239,400	169	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	1,068	1,068	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	1,293,398	1,293,398	0	0	0	8.00
9.00	60.00	LABORATORY	879,911	753,911	126,000	260,300	587	9.00
10.00	91.00	EMERGENCY	4,630,136	4,630,136	0	0	0	10.00
200.00			14,447,630	13,735,579	712,051		3,951	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	324,876	16,244	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	23,392	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	19,451	973	35,669	447	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	0	4,767	0	0	8.00
9.00	60.00	LABORATORY	73,460	3,673	12,087	1,731	0	9.00
10.00	91.00	EMERGENCY	0	0	5,233	0	0	10.00
200.00			417,787	20,890	81,148	2,178	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	324,876	230,762	391,692		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,839,692		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	110,402		3.00
4.00	50.00	OPERATING ROOM	0	0	0	551,562		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	96		5.00
6.00	53.00	ANESTHESIOLOGY	0	19,898	10,515	2,404,899		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,068		7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	0	0	1,293,398		8.00
9.00	60.00	LABORATORY	0	75,191	50,809	804,720		9.00
10.00	91.00	EMERGENCY	0	0	0	4,630,136		10.00
200.00			0	419,965	292,086	14,027,665		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,266,369	3,266,369			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,285,461		3,285,461		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,387,777	44,959	30,954	14,463,690	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,859,244	670,209	1,056,134	2,661,145	5.00
6.00	00600	MAINTENANCE & REPAIRS	540,586	0	3,523	94,396	6.00
7.00	00700	OPERATION OF PLANT	3,596,645	130,264	75,651	182,024	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	332,783	17,942	0	5,755	8.00
9.00	00900	HOUSEKEEPING	1,244,713	7,786	4,463	145,456	9.00
10.00	01000	DIETARY	1,214,051	40,673	5,207	209,530	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,585,216	4,337	243,778	227,236	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	348,086	11,420	5,034	37,214	14.00
15.00	01500	PHARMACY	711,962	14,057	13,362	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,905,847	38,236	55,299	160,952	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,108,566	288,098	50,867	1,297,782	30.00
31.00	03100	INTENSIVE CARE UNIT	2,119,494	48,727	60,620	357,315	31.00
41.00	04100	SUBPROVIDER - IRF	2,152,965	62,792	31,261	197,523	41.00
43.00	04300	NURSERY	401,351	3,483	9,144	52,807	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,786,810	74,003	549,726	331,707	50.00
51.00	05100	RECOVERY ROOM	1,271,362	58,288	561	221,309	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,042,375	0	19,606	160,657	52.00
53.00	05300	ANESTHESIOLOGY	244,094	3,140	25,926	12,835	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,805,621	89,022	197,236	278,534	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,604,482	161,083	160,938	159,886	55.00
56.00	05600	RADIOISOTOPE	580,459	10,390	97,540	23,429	56.00
57.00	05700	CT SCAN	757,663	4,789	89,730	61,711	57.00
58.00	05800	MRI	449,601	7,066	72,332	26,553	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,185,552	30,517	32,903	133,849	59.00
60.00	06000	LABORATORY	4,388,596	50,217	91,196	331,653	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	586,982	1,130	437	24,621	62.00
64.00	06400	INTRAVENOUS THERAPY	610,054	58,355	21,915	104,255	64.00
65.00	06500	RESPIRATORY THERAPY	1,149,562	21,734	7,161	176,672	65.00
66.00	06600	PHYSICAL THERAPY	1,398,462	31,480	657	105,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	623,922	1,306	0	12,740	67.00
68.00	06800	SPEECH PATHOLOGY	272,324	536	0	44,951	68.00
69.00	06900	ELECTROCARDIOLOGY	109,208	0	14,074	14,353	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	217,317	6,011	9,708	35,345	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,860,469	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,159,087	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,063,942	0	0	353,351	73.00
74.00	07400	RENAL DIALYSIS	103,931	0	0	0	74.00
76.00	03950	DIABETES CENTER	109,407	0	0	19,120	76.00
76.97	07697	CARDIAC REHABILITATION	207,956	22,161	3,424	36,531	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	113,060	0	0	19,631	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	758,110	0	2,914	117,554	88.00
88.01	08801	RURAL HEALTH CLINIC II	542,835	0	24,116	65,955	88.01
88.02	08802	RURAL HEALTH CLINIC III	687,035	48,032	1,593	101,101	88.02
88.03	08803	RURAL HEALTH CLINIC IV	895,272	0	2,305	114,613	88.03
88.04	08804	RURAL HEALTH CLINIC V	2,204,227	0	33,251	328,072	88.04
88.05	08805	RURAL HEALTH CLINIC VI	154,096	10,047	0	20,958	88.05
88.06	08806	RURAL HEALTH CLINIC VII	343,077	28,926	0	51,642	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	196,100	6,371	0	34,767	88.07
88.08	08808	RURAL HEALTH CLINIC IX	4,871,374	448,436	0	791,288	88.08
88.09	08809	RURAL HEALTH CLINIC X	463,866	3,600	937	76,023	88.09
91.00	09100	EMERGENCY	3,036,502	245,835	25,844	452,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,622,798	25,117	29,222	264,146	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,538,706	2,830,575	3,160,549	10,736,595	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,554,185	329,106	123,679	3,607,711	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	735,239	84,820	1,233	119,384	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.02	07952	HWY 61 BUILDING	0	21,868	0	0	21,868	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	157,828,130	3,266,369	3,285,461	14,463,690	157,828,130	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,246,732					5.00
6.00	00600	MAINTENANCE & REPAIRS	163,955	802,460				6.00
7.00	00700	OPERATION OF PLANT	1,023,161	40,974	5,048,719			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,537	5,643	37,417	491,077		8.00
9.00	00900	HOUSEKEEPING	360,113	2,449	16,238	0	1,781,218	9.00
10.00	01000	DIETARY	377,328	12,793	84,820	0	30,246	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	529,112	1,364	9,044	0	3,225	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	103,162	3,592	23,815	0	8,492	14.00
15.00	01500	PHARMACY	189,858	4,422	29,315	0	10,454	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	554,731	12,027	79,739	0	28,435	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,759,181	90,619	600,812	179,792	214,247	30.00
31.00	03100	INTENSIVE CARE UNIT	664,073	15,327	101,617	21,534	36,236	31.00
41.00	04100	SUBPROVIDER - IRF	627,709	19,751	130,949	31,759	46,696	41.00
43.00	04300	NURSERY	119,861	1,096	7,263	0	2,590	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	960,934	23,277	154,328	59,746	55,033	50.00
51.00	05100	RECOVERY ROOM	398,399	18,334	121,556	21,316	43,346	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	313,949	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	73,438	988	6,547	0	2,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	865,455	28,001	185,651	40,354	66,202	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	535,743	50,667	335,928	8,292	119,791	55.00
56.00	05600	RADIOISOTOPE	182,781	3,268	21,668	0	7,727	56.00
57.00	05700	CT SCAN	234,669	1,506	9,987	0	3,561	57.00
58.00	05800	MRI	142,655	2,223	14,736	0	5,255	58.00
59.00	05900	CARDIAC CATHETERIZATION	355,081	9,599	63,641	7,121	22,694	59.00
60.00	06000	LABORATORY	1,248,378	15,795	104,724	1	37,344	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	157,450	356	2,357	0	841	62.00
64.00	06400	INTRAVENOUS THERAPY	204,032	18,355	121,695	5,945	43,396	64.00
65.00	06500	RESPIRATORY THERAPY	347,970	6,836	45,326	0	16,163	65.00
66.00	06600	PHYSICAL THERAPY	394,459	9,902	65,649	1,986	23,410	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,817	411	2,724	0	971	67.00
68.00	06800	SPEECH PATHOLOGY	81,608	169	1,117	0	398	68.00
69.00	06900	ELECTROCARDIOLOGY	35,342	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	68,915	1,891	12,536	2,451	4,470	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,018,411	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,067,970	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,674,952	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	26,687	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	33,003	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	69,349	6,971	46,216	0	16,481	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	34,072	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	225,601	0	0	330	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	162,518	0	0	220	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	215,120	15,108	100,167	387	35,719	88.02
88.03	08803	RURAL HEALTH CLINIC IV	259,910	0	0	2,399	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	658,782	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	47,530	3,160	20,952	0	7,471	88.05
88.06	08806	RURAL HEALTH CLINIC VII	108,784	9,099	60,324	0	21,511	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	60,918	2,004	13,287	0	4,738	88.07
88.08	08808	RURAL HEALTH CLINIC IX	1,569,208	141,049	935,189	0	333,484	88.08
88.09	08809	RURAL HEALTH CLINIC X	139,798	1,132	7,508	20	2,677	88.09
91.00	09100	EMERGENCY	965,558	77,326	512,675	107,424	182,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	498,483	7,900	52,380	0	18,678	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,165,510	665,384	4,139,897	491,077	1,457,135	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,834,060	103,518	686,331	0	244,743	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	241,547	26,679	176,886	0	63,077	194.01
194.02	07952	HWY 61 BUILDING	5,615	6,879	45,605	0	16,263	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,246,732	802,460	5,048,719	491,077	1,781,218	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,974,648					10.00
11.00	01100	CAFETERIA	1,419,940	1,419,940				11.00
13.00	01300	NURSING ADMINISTRATION	0	35,699	2,639,011			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,460	0	552,275		14.00
15.00	01500	PHARMACY	0	53,772	0	0	1,027,202	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,379	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	417,375	311,834	1,180,610	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	54,017	60,809	273,298	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	83,316	40,876	176,621	0	0	41.00
43.00	04300	NURSERY	0	7,860	35,379	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	73,775	298,759	0	0	50.00
51.00	05100	RECOVERY ROOM	0	40,876	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,910	118,105	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	25,580	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,949	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	17,226	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	3,671	0	0	0	56.00
57.00	05700	CT SCAN	0	10,025	0	0	0	57.00
58.00	05800	MRI	0	4,730	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	33,299	0	0	0	59.00
60.00	06000	LABORATORY	0	90,460	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,871	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	18,473	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	36,287	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	30,545	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,495	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,319	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,871	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,495	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	361,173	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	191,102	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,027,202	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	3,765	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,424	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,965	13,377	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	80,529	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	12,166	0	0	0	88.09
91.00	09100	EMERGENCY	0	109,027	352,819	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	190,043	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,974,648	1,249,422	2,639,011	552,275	1,027,202	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	170,518	0	0	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	0	0	0	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,974,648	1,419,940	2,639,011	552,275	1,027,202	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,851,645				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,575,063	18,074,846	57,012	18,131,858	30.00
31.00	03100	INTENSIVE CARE UNIT	114,114	3,927,181	-54,834	3,872,347	31.00
41.00	04100	SUBPROVIDER - IRF	392,470	3,994,688	0	3,994,688	41.00
43.00	04300	NURSERY	342,221	983,055	0	983,055	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,368,098	0	5,368,098	50.00
51.00	05100	RECOVERY ROOM	0	2,195,347	0	2,195,347	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,682,602	0	1,682,602	52.00
53.00	05300	ANESTHESIOLOGY	0	394,883	0	394,883	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,609,025	0	4,609,025	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,154,036	0	3,154,036	55.00
56.00	05600	RADIOISOTOPE	0	930,933	0	930,933	56.00
57.00	05700	CT SCAN	0	1,173,641	0	1,173,641	57.00
58.00	05800	MRI	0	725,151	0	725,151	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,874,256	0	1,874,256	59.00
60.00	06000	LABORATORY	0	6,358,364	0	6,358,364	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	779,045	0	779,045	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,206,475	-2,178	1,204,297	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,807,711	0	1,807,711	65.00
66.00	06600	PHYSICAL THERAPY	0	2,062,125	0	2,062,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	814,386	0	814,386	67.00
68.00	06800	SPEECH PATHOLOGY	0	408,422	0	408,422	68.00
69.00	06900	ELECTROCARDIOLOGY	0	175,848	0	175,848	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	365,139	0	365,139	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,240,053	0	10,240,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,418,159	0	5,418,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,119,447	0	14,119,447	73.00
74.00	07400	RENAL DIALYSIS	0	130,618	0	130,618	74.00
76.00	03950	DIABETES CENTER	0	165,295	0	165,295	76.00
76.97	07697	CARDIAC REHABILITATION	0	415,513	0	415,513	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	183,105	0	183,105	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,104,509	0	1,104,509	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	795,644	0	795,644	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,204,262	0	1,204,262	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,274,499	0	1,274,499	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	3,224,332	0	3,224,332	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	264,214	0	264,214	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	623,363	0	623,363	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	318,185	0	318,185	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	9,170,557	0	9,170,557	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	707,727	0	707,727	88.09
91.00	09100	EMERGENCY	427,777	6,495,678	0	6,495,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,708,767	0	2,708,767	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,851,645	121,629,184	0	121,629,184	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	34,653,851	0	34,653,851	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,448,865	0	1,448,865	194.01
194.02	07952	HWY 61 BUILDING	0	96,230	0	96,230	194.02
200.00		Cross Foot Adjustments		0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	2,851,645	157,828,130	0	157,828,130		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,761	44,959	30,954	82,674	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	349,688	670,209	1,056,134	2,076,031	5.00
6.00	00600	MAINTENANCE & REPAIRS	304	0	3,523	3,827	6.00
7.00	00700	OPERATION OF PLANT	126,395	130,264	75,651	332,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,412	17,942	0	19,354	8.00
9.00	00900	HOUSEKEEPING	6,066	7,786	4,463	18,315	9.00
10.00	01000	DIETARY	5,393	40,673	5,207	51,273	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,519	4,337	243,778	264,634	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,027	11,420	5,034	18,481	14.00
15.00	01500	PHARMACY	152,500	14,057	13,362	179,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,769	38,236	55,299	99,304	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	40,698	288,098	50,867	379,663	30.00
31.00	03100	INTENSIVE CARE UNIT	8,239	48,727	60,620	117,586	31.00
41.00	04100	SUBPROVIDER - IRF	4,215	62,792	31,261	98,268	41.00
43.00	04300	NURSERY	571	3,483	9,144	13,198	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	288,188	74,003	549,726	911,917	50.00
51.00	05100	RECOVERY ROOM	540	58,288	561	59,389	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,575	0	19,606	21,181	52.00
53.00	05300	ANESTHESIOLOGY	2,674	3,140	25,926	31,740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	363,895	89,022	197,236	650,153	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	322,619	161,083	160,938	644,640	55.00
56.00	05600	RADIOISOTOPE	124,974	10,390	97,540	232,904	56.00
57.00	05700	CT SCAN	21,215	4,789	89,730	115,734	57.00
58.00	05800	MRI	155,425	7,066	72,332	234,823	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,941	30,517	32,903	67,361	59.00
60.00	06000	LABORATORY	34,682	50,217	91,196	176,095	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	289	1,130	437	1,856	62.00
64.00	06400	INTRAVENOUS THERAPY	4,503	58,355	21,915	84,773	64.00
65.00	06500	RESPIRATORY THERAPY	38,858	21,734	7,161	67,753	65.00
66.00	06600	PHYSICAL THERAPY	6,844	31,480	657	38,981	66.00
67.00	06700	OCCUPATIONAL THERAPY	85	1,306	0	1,391	67.00
68.00	06800	SPEECH PATHOLOGY	1,939	536	0	2,475	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	14,074	14,074	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,480	6,011	9,708	21,199	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	200	0	0	200	76.00
76.97	07697	CARDIAC REHABILITATION	741	22,161	3,424	26,326	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	388	0	0	388	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	21,990	0	2,914	24,904	88.00
88.01	08801	RURAL HEALTH CLINIC II	82,576	0	24,116	106,692	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,514	48,032	1,593	52,139	88.02
88.03	08803	RURAL HEALTH CLINIC IV	47,846	0	2,305	50,151	88.03
88.04	08804	RURAL HEALTH CLINIC V	260,670	0	33,251	293,921	88.04
88.05	08805	RURAL HEALTH CLINIC VI	12,537	10,047	0	22,584	88.05
88.06	08806	RURAL HEALTH CLINIC VII	26,553	28,926	0	55,479	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	787	6,371	0	7,158	88.07
88.08	08808	RURAL HEALTH CLINIC IX	18,159	448,436	0	466,595	88.08
88.09	08809	RURAL HEALTH CLINIC X	11,989	3,600	937	16,526	88.09
91.00	09100	EMERGENCY	6,745	245,835	25,844	278,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	13,880	25,117	29,222	68,219	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,611,858	2,830,575	3,160,549	8,602,982	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	155,129	329,106	123,679	607,914	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	10,134	84,820	1,233	96,187	194.01
194.02	07952	HWY 61 BUILDING	0	21,868	0	21,868	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,777,121	3,266,369	3,285,461	9,328,951	82,674	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,091,248					5.00
6.00	00600	MAINTENANCE & REPAIRS	10,633	15,000				6.00
7.00	00700	OPERATION OF PLANT	66,355	766	400,472			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,936	105	2,968	28,396		8.00
9.00	00900	HOUSEKEEPING	23,354	46	1,288	0	43,835	9.00
10.00	01000	DIETARY	24,471	239	6,728	0	744	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	34,315	25	717	0	79	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,690	67	1,889	0	209	14.00
15.00	01500	PHARMACY	12,313	83	2,325	0	257	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,976	225	6,325	0	700	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	178,942	1,694	47,657	10,396	5,273	30.00
31.00	03100	INTENSIVE CARE UNIT	43,067	286	8,060	1,245	892	31.00
41.00	04100	SUBPROVIDER - IRF	40,709	369	10,387	1,836	1,149	41.00
43.00	04300	NURSERY	7,773	20	576	0	64	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,320	435	12,242	3,455	1,354	50.00
51.00	05100	RECOVERY ROOM	25,837	343	9,642	1,233	1,067	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,361	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,763	18	519	0	57	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,127	523	14,726	2,333	1,629	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	34,745	947	26,646	479	2,948	55.00
56.00	05600	RADIOISOTOPE	11,854	61	1,719	0	190	56.00
57.00	05700	CT SCAN	15,219	28	792	0	88	57.00
58.00	05800	MRI	9,252	42	1,169	0	129	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,028	179	5,048	412	558	59.00
60.00	06000	LABORATORY	80,961	295	8,307	0	919	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,211	7	187	0	21	62.00
64.00	06400	INTRAVENOUS THERAPY	13,232	343	9,653	344	1,068	64.00
65.00	06500	RESPIRATORY THERAPY	22,567	128	3,595	0	398	65.00
66.00	06600	PHYSICAL THERAPY	25,582	185	5,207	115	576	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,624	8	216	0	24	67.00
68.00	06800	SPEECH PATHOLOGY	5,293	3	89	0	10	68.00
69.00	06900	ELECTROCARDIOLOGY	2,292	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,469	35	994	142	110	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	130,900	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,261	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	173,479	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,731	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	2,140	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,498	130	3,666	0	406	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,210	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	14,631	0	0	19	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	10,540	0	0	13	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	13,951	282	7,945	22	879	88.02
88.03	08803	RURAL HEALTH CLINIC IV	16,856	0	0	139	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	42,724	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,082	59	1,662	0	184	88.05
88.06	08806	RURAL HEALTH CLINIC VII	7,055	170	4,785	0	529	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	3,951	37	1,054	0	117	88.07
88.08	08808	RURAL HEALTH CLINIC IX	101,768	2,640	74,183	0	8,207	88.08
88.09	08809	RURAL HEALTH CLINIC X	9,066	21	596	1	66	88.09
91.00	09100	EMERGENCY	62,620	1,445	40,666	6,212	4,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	32,328	148	4,155	0	460	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,632,062	12,437	328,383	28,396	35,860	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	443,157	1,935	54,441	0	6,023	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	15,665	499	14,031	0	1,552	194.01
194.02	07952	HWY 61 BUILDING	364	129	3,617	0	400	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,091,248	15,000	400,472	28,396	43,835	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	84,653					10.00
11.00	01100	CAFETERIA	60,872	60,872				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,530	302,599			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	491	0	28,040		14.00
15.00	01500	PHARMACY	0	2,305	0	0	197,202	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	702	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,893	13,371	135,373	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,316	2,607	31,337	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	3,572	1,752	20,252	0	0	41.00
43.00	04300	NURSERY	0	337	4,057	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,163	34,257	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,752	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,196	13,542	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,097	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,270	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	738	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	157	0	0	0	56.00
57.00	05700	CT SCAN	0	430	0	0	0	57.00
58.00	05800	MRI	0	203	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,427	0	0	0	59.00
60.00	06000	LABORATORY	0	3,878	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	209	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	792	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,556	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,309	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	364	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	314	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	123	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	278	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,337	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,703	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	197,202	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	161	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	275	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	127	1,534	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	3,452	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	522	0	0	0	88.09
91.00	09100	EMERGENCY	0	4,674	40,456	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	21,791	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,653	53,562	302,599	28,040	197,202	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,310	0	0	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	0	0	0	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	84,653	60,872	302,599	28,040	197,202	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144,152				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	79,620	877,303	0	877,303	30.00
31.00	03100	INTENSIVE CARE UNIT	5,769	215,208	0	215,208	31.00
41.00	04100	SUBPROVIDER - IRF	19,840	199,263	0	199,263	41.00
43.00	04300	NURSERY	17,299	43,626	0	43,626	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,031,040	0	1,031,040	50.00
51.00	05100	RECOVERY ROOM	0	100,528	0	100,528	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	57,199	0	57,199	52.00
53.00	05300	ANESTHESIOLOGY	0	38,267	0	38,267	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	729,354	0	729,354	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	712,057	0	712,057	55.00
56.00	05600	RADIOISOTOPE	0	247,019	0	247,019	56.00
57.00	05700	CT SCAN	0	132,644	0	132,644	57.00
58.00	05800	MRI	0	245,770	0	245,770	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	98,778	0	98,778	59.00
60.00	06000	LABORATORY	0	272,351	0	272,351	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	12,632	0	12,632	62.00
64.00	06400	INTRAVENOUS THERAPY	0	110,801	0	110,801	64.00
65.00	06500	RESPIRATORY THERAPY	0	97,007	0	97,007	65.00
66.00	06600	PHYSICAL THERAPY	0	72,559	0	72,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,700	0	12,700	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,441	0	8,441	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,571	0	16,571	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	27,429	0	27,429	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	149,237	0	149,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	78,964	0	78,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	372,702	0	372,702	73.00
74.00	07400	RENAL DIALYSIS	0	1,731	0	1,731	74.00
76.00	03950	DIABETES CENTER	0	2,610	0	2,610	76.00
76.97	07697	CARDIAC REHABILITATION	0	35,510	0	35,510	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	4,371	0	4,371	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	40,226	0	40,226	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	117,622	0	117,622	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	75,796	0	75,796	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	67,801	0	67,801	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	338,521	0	338,521	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	27,691	0	27,691	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	68,313	0	68,313	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	12,516	0	12,516	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	661,370	0	661,370	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	27,233	0	27,233	88.09
91.00	09100	EMERGENCY	21,624	463,205	0	463,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	128,611	0	128,611	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,152	8,032,577	0	8,032,577	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,141,379	0	1,141,379	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	128,617	0	128,617	194.01
194.02	07952	HWY 61 BUILDING	0	26,378	0	26,378	194.02
200.00		Cross Foot Adjustments		0	0	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	144,152	9,328,951	0	9,328,951		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	390,141				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,285,461			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,370	30,954	71,544,646		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	80,051	1,056,134	13,163,361	-32,246,732	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	3,523	466,928	0	6.00
7.00	00700	OPERATION OF PLANT	15,559	75,651	900,383	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,143	0	28,465	0	8.00
9.00	00900	HOUSEKEEPING	930	4,463	719,497	0	9.00
10.00	01000	DIETARY	4,858	5,207	1,036,440	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	518	243,778	1,124,024	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	5,034	184,081	0	14.00
15.00	01500	PHARMACY	1,679	13,362	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,567	55,299	796,152	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,411	50,867	6,419,483	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	60,620	1,767,460	0	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	31,261	977,049	0	41.00
43.00	04300	NURSERY	416	9,144	261,210	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,839	549,726	1,640,790	0	50.00
51.00	05100	RECOVERY ROOM	6,962	561	1,094,705	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,606	794,690	0	52.00
53.00	05300	ANESTHESIOLOGY	375	25,926	63,490	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	197,236	1,377,767	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	160,938	790,879	0	55.00
56.00	05600	RADIOISOTOPE	1,241	97,540	115,894	0	56.00
57.00	05700	CT SCAN	572	89,730	305,255	0	57.00
58.00	05800	MRI	844	72,332	131,343	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	32,903	662,083	0	59.00
60.00	06000	LABORATORY	5,998	91,196	1,640,521	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	437	121,787	0	62.00
64.00	06400	INTRAVENOUS THERAPY	6,970	21,915	515,698	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,596	7,161	873,910	0	65.00
66.00	06600	PHYSICAL THERAPY	3,760	657	522,226	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	156	0	63,019	0	67.00
68.00	06800	SPEECH PATHOLOGY	64	0	222,350	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,074	70,996	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	718	9,708	174,836	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,747,854	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	0	94,579	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,647	3,424	180,703	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	97,107	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,914	581,480	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	24,116	326,249	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	1,593	500,095	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,305	566,934	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	33,251	1,622,807	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,200	0	103,667	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	3,455	0	255,445	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	761	0	171,976	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	53,562	0	3,914,108	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	430	937	376,046	0	88.09
91.00	09100	EMERGENCY	29,363	25,844	2,236,179	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,000	29,222	1,306,599	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338,089	3,160,549	53,108,600	-32,246,732	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,309	123,679	17,845,513	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	10,131	1,233	590,533	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
194.02	07952	HWY 61 BUILDING	2,612	0	0	0	21,868	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,266,369	3,285,461	14,463,690		32,246,732	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.372278	1.000000	0.202163		0.256780	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			82,674		2,091,248	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001156		0.016653	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	304,720					6.00
7.00	00700	OPERATION OF PLANT	15,559	289,161				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,143	2,143	526,392			8.00
9.00	00900	HOUSEKEEPING	930	930	0	286,088		9.00
10.00	01000	DIETARY	4,858	4,858	0	4,858	308,937	10.00
11.00	01100	CAFETERIA	0	0	0	0	222,152	11.00
13.00	01300	NURSING ADMINISTRATION	518	518	0	518	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	1,364	0	1,364	0	14.00
15.00	01500	PHARMACY	1,679	1,679	0	1,679	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,567	4,567	0	4,567	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,411	34,411	192,721	34,411	65,299	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	5,820	23,083	5,820	8,451	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	7,500	34,043	7,500	13,035	41.00
43.00	04300	NURSERY	416	416	0	416	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,839	8,839	64,043	8,839	0	50.00
51.00	05100	RECOVERY ROOM	6,962	6,962	22,849	6,962	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	375	375	0	375	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	10,633	43,256	10,633	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	19,240	8,888	19,240	0	55.00
56.00	05600	RADIOISOTOPE	1,241	1,241	0	1,241	0	56.00
57.00	05700	CT SCAN	572	572	0	572	0	57.00
58.00	05800	MRI	844	844	0	844	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	3,645	7,633	3,645	0	59.00
60.00	06000	LABORATORY	5,998	5,998	1	5,998	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	135	0	135	0	62.00
64.00	06400	INTRAVENOUS THERAPY	6,970	6,970	6,373	6,970	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,596	2,596	0	2,596	0	65.00
66.00	06600	PHYSICAL THERAPY	3,760	3,760	2,129	3,760	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	156	156	0	156	0	67.00
68.00	06800	SPEECH PATHOLOGY	64	64	0	64	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	718	718	2,627	718	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,647	2,647	0	2,647	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	354	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	236	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	5,737	415	5,737	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	2,571	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,200	1,200	0	1,200	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	3,455	3,455	0	3,455	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	761	761	0	761	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	53,562	53,562	0	53,562	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	430	430	21	430	0	88.09
91.00	09100	EMERGENCY	29,363	29,363	115,149	29,363	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,000	3,000	0	3,000	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	252,668	237,109	526,392	234,036	308,937	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,309	39,309	0	39,309	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	10,131	10,131	0	10,131	0	194.01
194.02	07952	HWY 61 BUILDING	2,612	2,612	0	2,612	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	802,460	5,048,719	491,077	1,781,218	1,974,648	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.633434	17.459889	0.932911	6.226119	6.391750	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,000	400,472	28,396	43,835	84,653	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.049226	1.384945	0.053945	0.153222	0.274014	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	60,339					11.00
13.00	01300	NURSING ADMINISTRATION	1,517	518,865				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	487	0	12,019,556			14.00
15.00	01500	PHARMACY	2,285	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	696	0	0	0	23,665	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,251	232,124	0	0	13,071	30.00
31.00	03100	INTENSIVE CARE UNIT	2,584	53,734	0	0	947	31.00
41.00	04100	SUBPROVIDER - IRF	1,737	34,726	0	0	3,257	41.00
43.00	04300	NURSERY	334	6,956	0	0	2,840	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,135	58,740	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,737	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,186	23,221	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,087	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,250	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	732	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	156	0	0	0	0	56.00
57.00	05700	CT SCAN	426	0	0	0	0	57.00
58.00	05800	MRI	201	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,415	0	0	0	0	59.00
60.00	06000	LABORATORY	3,844	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	207	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	785	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,542	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,298	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	361	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	311	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	122	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	276	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	7,860,469	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,159,087	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	160	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	273	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	126	2,630	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	3,422	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	517	0	0	0	0	88.09
91.00	09100	EMERGENCY	4,633	69,369	0	0	3,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	37,365	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,093	518,865	12,019,556	100	23,665	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,246	0	0	0	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	0	0	0	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,419,940	2,639,011	552,275	1,027,202	2,851,645	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	23.532707	5.086123	0.045948	10,272.020000	120.500528	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	60,872	302,599	28,040	197,202	144,152	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.008833	0.583194	0.002333	1,972.020000	6.091359	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-2

Date/Time Prepared:
2/28/2020 9:20 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		ICU OBSERVATION & IV THERAPY		1	30.00	57,012 7.00
8.00		ICU OBSERVATION		1	31.00	-54,834 8.00
9.00		IV THERAPY		1	64.00	-2,178 9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:20 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,131,858		18,131,858	0	18,131,858	30.00
31.00	03100	INTENSIVE CARE UNIT	3,872,347		3,872,347	0	3,872,347	31.00
41.00	04100	SUBPROVIDER - IRF	3,994,688		3,994,688	0	3,994,688	41.00
43.00	04300	NURSERY	983,055		983,055	0	983,055	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,368,098		5,368,098	0	5,368,098	50.00
51.00	05100	RECOVERY ROOM	2,195,347		2,195,347	0	2,195,347	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,682,602		1,682,602	0	1,682,602	52.00
53.00	05300	ANESTHESIOLOGY	394,883		394,883	10,515	405,398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,609,025		4,609,025	0	4,609,025	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,154,036		3,154,036	0	3,154,036	55.00
56.00	05600	RADIOISOTOPE	930,933		930,933	0	930,933	56.00
57.00	05700	CT SCAN	1,173,641		1,173,641	0	1,173,641	57.00
58.00	05800	MRI	725,151		725,151	0	725,151	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,874,256		1,874,256	0	1,874,256	59.00
60.00	06000	LABORATORY	6,358,364		6,358,364	50,809	6,409,173	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	779,045		779,045	0	779,045	62.00
64.00	06400	INTRAVENOUS THERAPY	1,204,297		1,204,297	0	1,204,297	64.00
65.00	06500	RESPIRATORY THERAPY	1,807,711	0	1,807,711	0	1,807,711	65.00
66.00	06600	PHYSICAL THERAPY	2,062,125	0	2,062,125	0	2,062,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	814,386	0	814,386	0	814,386	67.00
68.00	06800	SPEECH PATHOLOGY	408,422	0	408,422	0	408,422	68.00
69.00	06900	ELECTROCARDIOLOGY	175,848		175,848	0	175,848	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	365,139		365,139	0	365,139	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,240,053		10,240,053	0	10,240,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,418,159		5,418,159	0	5,418,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,119,447		14,119,447	0	14,119,447	73.00
74.00	07400	RENAL DIALYSIS	130,618		130,618	0	130,618	74.00
76.00	03950	DIABETES CENTER	165,295		165,295	0	165,295	76.00
76.97	07697	CARDIAC REHABILITATION	415,513		415,513	0	415,513	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	183,105		183,105	0	183,105	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,104,509		1,104,509	0	1,104,509	88.00
88.01	08801	RURAL HEALTH CLINIC II	795,644		795,644	0	795,644	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,204,262		1,204,262	0	1,204,262	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,274,499		1,274,499	0	1,274,499	88.03
88.04	08804	RURAL HEALTH CLINIC V	3,224,332		3,224,332	0	3,224,332	88.04
88.05	08805	RURAL HEALTH CLINIC VI	264,214		264,214	0	264,214	88.05
88.06	08806	RURAL HEALTH CLINIC VII	623,363		623,363	0	623,363	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	318,185		318,185	0	318,185	88.07
88.08	08808	RURAL HEALTH CLINIC IX	9,170,557		9,170,557	0	9,170,557	88.08
88.09	08809	RURAL HEALTH CLINIC X	707,727		707,727	0	707,727	88.09
91.00	09100	EMERGENCY	6,495,678		6,495,678	0	6,495,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,304,717		1,304,717	0	1,304,717	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,708,767		2,708,767	0	2,708,767	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	122,933,901	0	122,933,901	61,324	122,995,225	200.00
201.00		Less Observation Beds	1,304,717		1,304,717		1,304,717	201.00
202.00		Total (see instructions)	121,629,184	0	121,629,184	61,324	121,690,508	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:20 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,285,745		9,285,745		30.00
31.00	03100	INTENSIVE CARE UNIT	1,821,980		1,821,980		31.00
41.00	04100	SUBPROVIDER - IRF	2,573,380		2,573,380		41.00
43.00	04300	NURSERY	290,669		290,669		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,153,619	27,351,078	41,504,697	0.129337	50.00
51.00	05100	RECOVERY ROOM	1,552,422	4,089,652	5,642,074	0.389103	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	801,582	255,877	1,057,459	1.591175	52.00
53.00	05300	ANESTHESIOLOGY	5,379,107	8,526,395	13,905,502	0.028398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,732,059	10,358,174	15,090,233	0.305431	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	44,901	5,643,026	5,687,927	0.554514	55.00
56.00	05600	RADIOISOTOPE	455,814	1,886,140	2,341,954	0.397503	56.00
57.00	05700	CT SCAN	6,073,489	18,143,722	24,217,211	0.048463	57.00
58.00	05800	MRI	742,534	4,850,422	5,592,956	0.129654	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,346,892	4,944,207	9,291,099	0.201726	59.00
60.00	06000	LABORATORY	12,323,575	24,711,156	37,034,731	0.171687	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	605,447	620,468	1,225,915	0.635480	62.00
64.00	06400	INTRAVENOUS THERAPY	107,732	2,247,346	2,355,078	0.511362	64.00
65.00	06500	RESPIRATORY THERAPY	4,076,393	849,306	4,925,699	0.366996	65.00
66.00	06600	PHYSICAL THERAPY	1,985,416	608,916	2,594,332	0.794858	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,270,293	553,057	1,823,350	0.446643	67.00
68.00	06800	SPEECH PATHOLOGY	215,643	1,061,931	1,277,574	0.319686	68.00
69.00	06900	ELECTROCARDIOLOGY	885,668	1,946,734	2,832,402	0.062084	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,308	633,057	639,365	0.571096	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,816,124	53,860,874	106,676,998	0.095991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,156,589	7,141,539	10,298,128	0.526130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,851,211	42,466,518	73,317,729	0.192579	73.00
74.00	07400	RENAL DIALYSIS	52,275	0	52,275	2.498670	74.00
76.00	03950	DIABETES CENTER	0	17,454	17,454	9.470322	76.00
76.97	07697	CARDIAC REHABILITATION	2,400	599,904	602,304	0.689873	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	6,602	13,650	20,252	9.041329	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,008,213	1,008,213		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	693,877	693,877		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,027,322	1,027,322		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	573,746	573,746		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,093,005	2,093,005		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	243,476	243,476		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	667,622	667,622		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	521,946	521,946		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	3,979,786	3,979,786		88.08
88.09	08809	RURAL HEALTH CLINIC X	0	616,795	616,795		88.09
91.00	09100	EMERGENCY	5,319,190	16,140,892	21,460,082	0.302687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	602,010	1,694,415	2,296,425	0.568151	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,248,636	2,248,636		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	166,537,069	254,890,334	421,427,403		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	166,537,069	254,890,334	421,427,403		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.129337			50.00
51.00	05100	RECOVERY ROOM	0.389103			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.591175			52.00
53.00	05300	ANESTHESIOLOGY	0.029154			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305431			54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.554514			55.00
56.00	05600	RADIOISOTOPE	0.397503			56.00
57.00	05700	CT SCAN	0.048463			57.00
58.00	05800	MRI	0.129654			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.201726			59.00
60.00	06000	LABORATORY	0.173058			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.635480			62.00
64.00	06400	INTRAVENOUS THERAPY	0.511362			64.00
65.00	06500	RESPIRATORY THERAPY	0.366996			65.00
66.00	06600	PHYSICAL THERAPY	0.794858			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.446643			67.00
68.00	06800	SPEECH PATHOLOGY	0.319686			68.00
69.00	06900	ELECTROCARDIOLOGY	0.062084			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.571096			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095991			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526130			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192579			73.00
74.00	07400	RENAL DIALYSIS	2.498670			74.00
76.00	03950	DIABETES CENTER	9.470322			76.00
76.97	07697	CARDIAC REHABILITATION	0.689873			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.041329			76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
88.06	08806	RURAL HEALTH CLINIC VII				88.06
88.07	08807	RURAL HEALTH CLINIC VIII				88.07
88.08	08808	RURAL HEALTH CLINIC IX				88.08
88.09	08809	RURAL HEALTH CLINIC X				88.09
91.00	09100	EMERGENCY	0.302687			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.568151			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:20 am

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	18,131,858		18,131,858	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,872,347		3,872,347	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	3,994,688		3,994,688	0	0	41.00	
43.00	04300	NURSERY	983,055		983,055	0	0	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	5,368,098		5,368,098	0	0	50.00	
51.00	05100	RECOVERY ROOM	2,195,347		2,195,347	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,682,602		1,682,602	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	394,883		394,883	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,609,025		4,609,025	0	0	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	3,154,036		3,154,036	0	0	55.00	
56.00	05600	RADIOISOTOPE	930,933		930,933	0	0	56.00	
57.00	05700	CT SCAN	1,173,641		1,173,641	0	0	57.00	
58.00	05800	MRI	725,151		725,151	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,874,256		1,874,256	0	0	59.00	
60.00	06000	LABORATORY	6,358,364		6,358,364	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	779,045		779,045	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	1,204,297		1,204,297	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	1,807,711	0	1,807,711	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	2,062,125	0	2,062,125	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	814,386	0	814,386	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	408,422	0	408,422	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	175,848		175,848	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	365,139		365,139	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,240,053		10,240,053	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,418,159		5,418,159	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	14,119,447		14,119,447	0	0	73.00	
74.00	07400	RENAL DIALYSIS	130,618		130,618	0	0	74.00	
76.00	03950	DIABETES CENTER	165,295		165,295	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	415,513		415,513	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	183,105		183,105	0	0	76.98	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	1,104,509		1,104,509	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	795,644		795,644	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	1,204,262		1,204,262	0	0	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	1,274,499		1,274,499	0	0	88.03	
88.04	08804	RURAL HEALTH CLINIC V	3,224,332		3,224,332	0	0	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	264,214		264,214	0	0	88.05	
88.06	08806	RURAL HEALTH CLINIC VII	623,363		623,363	0	0	88.06	
88.07	08807	RURAL HEALTH CLINIC VIII	318,185		318,185	0	0	88.07	
88.08	08808	RURAL HEALTH CLINIC IX	9,170,557		9,170,557	0	0	88.08	
88.09	08809	RURAL HEALTH CLINIC X	707,727		707,727	0	0	88.09	
91.00	09100	EMERGENCY	6,495,678		6,495,678	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,304,717		1,304,717	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	2,708,767		2,708,767		0	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	122,933,901	0	122,933,901	0	0	200.00	
201.00		Less Observation Beds	1,304,717		1,304,717		0	201.00	
202.00		Total (see instructions)	121,629,184	0	121,629,184	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:20 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,285,745		9,285,745		30.00
31.00	03100	INTENSIVE CARE UNIT	1,821,980		1,821,980		31.00
41.00	04100	SUBPROVIDER - IRF	2,573,380		2,573,380		41.00
43.00	04300	NURSERY	290,669		290,669		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,153,619	27,351,078	41,504,697	0.129337	50.00
51.00	05100	RECOVERY ROOM	1,552,422	4,089,652	5,642,074	0.389103	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	801,582	255,877	1,057,459	1.591175	52.00
53.00	05300	ANESTHESIOLOGY	5,379,107	8,526,395	13,905,502	0.028398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,732,059	10,358,174	15,090,233	0.305431	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	44,901	5,643,026	5,687,927	0.554514	55.00
56.00	05600	RADIOISOTOPE	455,814	1,886,140	2,341,954	0.397503	56.00
57.00	05700	CT SCAN	6,073,489	18,143,722	24,217,211	0.048463	57.00
58.00	05800	MRI	742,534	4,850,422	5,592,956	0.129654	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,346,892	4,944,207	9,291,099	0.201726	59.00
60.00	06000	LABORATORY	12,323,575	24,711,156	37,034,731	0.171687	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	605,447	620,468	1,225,915	0.635480	62.00
64.00	06400	INTRAVENOUS THERAPY	46,380	2,308,698	2,355,078	0.511362	64.00
65.00	06500	RESPIRATORY THERAPY	4,076,393	849,306	4,925,699	0.366996	65.00
66.00	06600	PHYSICAL THERAPY	1,985,416	608,916	2,594,332	0.794858	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,270,293	553,057	1,823,350	0.446643	67.00
68.00	06800	SPEECH PATHOLOGY	215,643	1,061,931	1,277,574	0.319686	68.00
69.00	06900	ELECTROCARDIOLOGY	885,668	1,946,734	2,832,402	0.062084	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,308	633,057	639,365	0.571096	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,816,124	53,860,874	106,676,998	0.095991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,156,589	7,141,539	10,298,128	0.526130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,851,211	42,466,518	73,317,729	0.192579	73.00
74.00	07400	RENAL DIALYSIS	52,275	0	52,275	2.498670	74.00
76.00	03950	DIABETES CENTER	0	17,454	17,454	9.470322	76.00
76.97	07697	CARDIAC REHABILITATION	2,400	599,904	602,304	0.689873	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	6,602	13,650	20,252	9.041329	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,008,213	1,008,213	1.095512	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	693,877	693,877	1.146664	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,027,322	1,027,322	1.172234	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	573,746	573,746	2.221365	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,093,005	2,093,005	1.540528	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	243,476	243,476	1.085175	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	667,622	667,622	0.933706	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	521,946	521,946	0.609613	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	3,979,786	3,979,786	2.304284	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	616,795	616,795	1.147427	88.09
91.00	09100	EMERGENCY	5,319,190	16,140,892	21,460,082	0.302687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	602,010	1,694,415	2,296,425	0.568151	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,248,636	2,248,636		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	166,475,717	254,951,686	421,427,403		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	166,475,717	254,951,686	421,427,403		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03950	DIABETES CENTER	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000			88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000			88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000			88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000			88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000			88.08
88.09	08809	RURAL HEALTH CLINIC X	0.000000			88.09
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part I Date/Time Prepared: 2/28/2020 9:20 am		
				Title XVIII		Hospital		PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	877,303	0	877,303	14,467	60.64	30.00	
31.00	INTENSIVE CARE UNIT	215,208		215,208	1,777	121.11	31.00	
41.00	SUBPROVIDER - IRF	199,263	0	199,263	2,871	69.41	41.00	
43.00	NURSERY	43,626		43,626	1,164	37.48	43.00	
200.00	Total (lines 30 through 199)	1,335,400		1,335,400	20,279		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,681	465,776					30.00
31.00	INTENSIVE CARE UNIT	993	120,262					31.00
41.00	SUBPROVIDER - IRF	2,125	147,496					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	10,799	733,534					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/28/2020 9:20 am			
				Title XVIII		Hospital		PPS	
	Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,031,040	41,504,697	0.024842	6,599,330	163,941	50.00	
51.00	05100	RECOVERY ROOM	100,528	5,642,074	0.017818	748,760	13,341	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,199	1,057,459	0.054091	2,141	116	52.00	
53.00	05300	ANESTHESIOLOGY	38,267	13,905,502	0.002752	2,004,860	5,517	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	729,354	15,090,233	0.048333	2,724,428	131,680	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	712,057	5,687,927	0.125187	22,503	2,817	55.00	
56.00	05600	RADIOISOTOPE	247,019	2,341,954	0.105476	254,582	26,852	56.00	
57.00	05700	CT SCAN	132,644	24,217,211	0.005477	3,421,544	18,740	57.00	
58.00	05800	MRI	245,770	5,592,956	0.043943	396,044	17,403	58.00	
59.00	05900	CARDIAC CATHETERIZATION	98,778	9,291,099	0.010631	1,928,388	20,501	59.00	
60.00	06000	LABORATORY	272,351	37,034,731	0.007354	6,969,729	51,255	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,632	1,225,915	0.010304	337,709	3,480	62.00	
64.00	06400	INTRAVENOUS THERAPY	110,801	2,355,078	0.047048	24,953	1,174	64.00	
65.00	06500	RESPIRATORY THERAPY	97,007	4,925,699	0.019694	2,492,842	49,094	65.00	
66.00	06600	PHYSICAL THERAPY	72,559	2,594,332	0.027968	616,264	17,236	66.00	
67.00	06700	OCCUPATIONAL THERAPY	12,700	1,823,350	0.006965	216,396	1,507	67.00	
68.00	06800	SPEECH PATHOLOGY	8,441	1,277,574	0.006607	55,746	368	68.00	
69.00	06900	ELECTROCARDIOLOGY	16,571	2,832,402	0.005851	521,130	3,049	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	27,429	639,365	0.042900	2,427	104	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,237	106,676,998	0.001399	24,093,964	33,707	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,964	10,298,128	0.007668	989,949	7,591	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	372,702	73,317,729	0.005083	14,408,679	73,239	73.00	
74.00	07400	RENAL DIALYSIS	1,731	52,275	0.033113	35,750	1,184	74.00	
76.00	03950	DIABETES CENTER	2,610	17,454	0.149536	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	35,510	602,304	0.058957	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,371	20,252	0.215831	199	43	76.98	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	40,226	1,008,213	0.039898	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	117,622	693,877	0.169514	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	75,796	1,027,322	0.073780	0	0	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	67,801	573,746	0.118173	0	0	88.03	
88.04	08804	RURAL HEALTH CLINIC V	338,521	2,093,005	0.161739	0	0	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	27,691	243,476	0.113732	0	0	88.05	
88.06	08806	RURAL HEALTH CLINIC VII	68,313	667,622	0.102323	0	0	88.06	
88.07	08807	RURAL HEALTH CLINIC VIII	12,516	521,946	0.023979	0	0	88.07	
88.08	08808	RURAL HEALTH CLINIC IX	661,370	3,979,786	0.166182	0	0	88.08	
88.09	08809	RURAL HEALTH CLINIC X	27,233	616,795	0.044152	0	0	88.09	
91.00	09100	EMERGENCY	463,205	21,460,082	0.021584	2,738,254	59,102	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	63,129	2,296,425	0.027490	310,860	8,546	92.00	
200.00		Total (lines 50 through 199)	6,631,695	405,206,993		71,917,431	711,587	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-0025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/28/2020 9:20 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	14,467	0.00	7,681		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,777	0.00	993		31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	2,871	0.00	2,125		41.00	
43.00	04300	NURSERY			0	1,164	0.00	0		43.00	
200.00		Total (lines 30 through 199)			0	20,279		10,799		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
41.00	04100	SUBPROVIDER - IRF		0						41.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:20 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V		0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI		0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII		0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII		0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX		0	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X		0	0	0	0	0	88.09
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 9:20 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	41,504,697	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,642,074	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,057,459	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,905,502	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,090,233	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	5,687,927	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,341,954	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	24,217,211	0.000000	57.00
58.00	05800	MRI	0	0	0	5,592,956	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,291,099	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	37,034,731	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,225,915	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,355,078	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,925,699	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,594,332	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,823,350	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,277,574	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,832,402	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	639,365	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	106,676,998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,298,128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73,317,729	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	52,275	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	17,454	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	602,304	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	20,252	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,008,213	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	693,877	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,027,322	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	573,746	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	2,093,005	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	243,476	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	667,622	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	521,946	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	3,979,786	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	616,795	0.000000	88.09
91.00	09100	EMERGENCY	0	0	0	21,460,082	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,296,425	0.000000	92.00
200.00	Total (lines 50 through 199)		0	0	0	405,206,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 9:20 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	6,599,330	0	10,702,881	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	748,760	0	1,424,250	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,141	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,004,860	0	2,699,325	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,724,428	0	3,091,220	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	22,503	0	2,520,966	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	254,582	0	884,283	0	56.00
57.00	05700	CT SCAN	0.000000	3,421,544	0	5,992,679	0	57.00
58.00	05800	MRI	0.000000	396,044	0	1,707,755	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,928,388	0	2,257,553	0	59.00
60.00	06000	LABORATORY	0.000000	6,969,729	0	4,152,443	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	337,709	0	190,931	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	24,953	0	1,070,936	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,492,842	0	364,219	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	616,264	0	9,840	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	216,396	0	7,680	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	55,746	0	150	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	521,130	0	708,628	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,427	0	192,280	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	24,093,964	0	21,270,979	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	989,949	0	3,409,784	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	14,408,679	0	15,193,782	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	35,750	0	0	0	74.00
76.00	03950	DIABETES CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	288,794	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	199	0	5,990	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0.000000	0	0	0	0	88.09
91.00	09100	EMERGENCY	0.000000	2,738,254	0	3,742,268	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	310,860	0	620,655	0	92.00
200.00		Total (lines 50 through 199)		71,917,431	0	82,510,271	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/28/2020 9:20 am

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.129337	10,702,881	0	0	1,384,279	50.00	
51.00	05100	RECOVERY ROOM	0.389103	1,424,250	0	0	554,180	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.591175	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.028398	2,699,325	0	0	76,655	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305431	3,091,220	0	0	944,154	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0.554514	2,520,966	0	0	1,397,911	55.00	
56.00	05600	RADIOISOTOPE	0.397503	884,283	0	0	351,505	56.00	
57.00	05700	CT SCAN	0.048463	5,992,679	0	0	290,423	57.00	
58.00	05800	MRI	0.129654	1,707,755	0	0	221,417	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.201726	2,257,553	0	0	455,407	59.00	
60.00	06000	LABORATORY	0.171687	4,152,443	849	0	712,920	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.635480	190,931	15	0	121,333	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.511362	1,070,936	0	0	547,636	64.00	
65.00	06500	RESPIRATORY THERAPY	0.366996	364,219	0	0	133,667	65.00	
66.00	06600	PHYSICAL THERAPY	0.794858	9,840	0	0	7,821	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.446643	7,680	0	0	3,430	67.00	
68.00	06800	SPEECH PATHOLOGY	0.319686	150	0	0	48	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.062084	708,628	0	0	43,994	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.571096	192,280	0	0	109,810	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095991	21,270,979	0	0	2,041,823	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526130	3,409,784	0	0	1,793,990	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192579	15,193,782	0	0	2,926,003	73.00	
74.00	07400	RENAL DIALYSIS	2.498670	0	0	0	0	74.00	
76.00	03950	DIABETES CENTER	9.470322	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.689873	288,794	0	0	199,231	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.041329	5,990	0	0	54,158	76.98	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	0.000000				0	88.03	
88.04	08804	RURAL HEALTH CLINIC V	0.000000				0	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	0.000000				0	88.05	
88.06	08806	RURAL HEALTH CLINIC VII	0.000000				0	88.06	
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000				0	88.07	
88.08	08808	RURAL HEALTH CLINIC IX	0.000000				0	88.08	
88.09	08809	RURAL HEALTH CLINIC X	0.000000				0	88.09	
91.00	09100	EMERGENCY	0.302687	3,742,268	0	0	1,132,736	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.568151	620,655	0	0	352,626	92.00	
200.00		Subtotal (see instructions)		82,510,271	864	0	15,857,157	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		82,510,271	864	0	15,857,157	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 26-0025		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/28/2020 9:20 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	146	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETES CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0		88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0		88.09
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	156	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	156	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:

Worksheet D

Component CCN: 26-T025

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,031,040	41,504,697	0.024842	1,728	43	50.00
51.00	05100 RECOVERY ROOM	100,528	5,642,074	0.017818	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	57,199	1,057,459	0.054091	0	0	52.00
53.00	05300 ANESTHESIOLOGY	38,267	13,905,502	0.002752	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	729,354	15,090,233	0.048333	55,275	2,672	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	712,057	5,687,927	0.125187	0	0	55.00
56.00	05600 RADIOISOTOPE	247,019	2,341,954	0.105476	0	0	56.00
57.00	05700 CT SCAN	132,644	24,217,211	0.005477	35,065	192	57.00
58.00	05800 MRI	245,770	5,592,956	0.043943	13,330	586	58.00
59.00	05900 CARDIAC CATHETERIZATION	98,778	9,291,099	0.010631	85	1	59.00
60.00	06000 LABORATORY	272,351	37,034,731	0.007354	204,435	1,503	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12,632	1,225,915	0.010304	12,922	133	62.00
64.00	06400 INTRAVENOUS THERAPY	110,801	2,355,078	0.047048	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	97,007	4,925,699	0.019694	101,027	1,990	65.00
66.00	06600 PHYSICAL THERAPY	72,559	2,594,332	0.027968	760,872	21,280	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,700	1,823,350	0.006965	675,765	4,707	67.00
68.00	06800 SPEECH PATHOLOGY	8,441	1,277,574	0.006607	75,503	499	68.00
69.00	06900 ELECTROCARDIOLOGY	16,571	2,832,402	0.005851	7,345	43	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	27,429	639,365	0.042900	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	149,237	106,676,998	0.001399	168,484	236	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	78,964	10,298,128	0.007668	337	3	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	372,702	73,317,729	0.005083	178,270	906	73.00
74.00	07400 RENAL DIALYSIS	1,731	52,275	0.033113	1,125	37	74.00
76.00	03950 DIABETES CENTER	2,610	17,454	0.149536	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	35,510	602,304	0.058957	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	4,371	20,252	0.215831	74	16	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	40,226	1,008,213	0.039898	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	117,622	693,877	0.169514	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	75,796	1,027,322	0.073780	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	67,801	573,746	0.118173	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	338,521	2,093,005	0.161739	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	27,691	243,476	0.113732	0	0	88.05
88.06	08806 RURAL HEALTH CLINIC VII	68,313	667,622	0.102323	0	0	88.06
88.07	08807 RURAL HEALTH CLINIC VIII	12,516	521,946	0.023979	0	0	88.07
88.08	08808 RURAL HEALTH CLINIC IX	661,370	3,979,786	0.166182	0	0	88.08
88.09	08809 RURAL HEALTH CLINIC X	27,233	616,795	0.044152	0	0	88.09
91.00	09100 EMERGENCY	463,205	21,460,082	0.021584	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,296,425	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	6,568,566	405,206,993		2,291,642	34,847	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:20 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V		0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI		0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII		0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII		0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX		0	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X		0	0	0	0	0	88.09
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:20 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	41,504,697	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	5,642,074	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	1,057,459	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,905,502	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	15,090,233	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	5,687,927	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	2,341,954	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	24,217,211	0.000000	57.00
58.00	05800	MRI		0	0	0	5,592,956	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	9,291,099	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	37,034,731	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	1,225,915	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	2,355,078	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	4,925,699	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	2,594,332	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,823,350	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,277,574	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	2,832,402	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	639,365	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	106,676,998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	10,298,128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	73,317,729	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	52,275	0.000000	74.00
76.00	03950	DIABETES CENTER		0	0	0	17,454	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	602,304	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	20,252	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,008,213	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	693,877	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	1,027,322	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	573,746	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V		0	0	0	2,093,005	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI		0	0	0	243,476	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII		0	0	0	667,622	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII		0	0	0	521,946	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX		0	0	0	3,979,786	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X		0	0	0	616,795	0.000000	88.09
91.00	09100	EMERGENCY		0	0	0	21,460,082	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,296,425	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	405,206,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:20 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		1,728	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		55,275	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		35,065	0	0	0	57.00
58.00	05800	MRI	0.000000		13,330	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		85	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		204,435	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		12,922	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		101,027	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		760,872	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		675,765	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		75,503	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		7,345	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		168,484	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		337	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		178,270	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		1,125	0	0	0	74.00
76.00	03950	DIABETES CENTER	0.000000		0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		74	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000		0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000		0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000		0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0.000000		0	0	0	0	88.09
91.00	09100	EMERGENCY	0.000000		0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0	92.00
200.00		Total (lines 50 through 199)			2,291,642	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/28/2020 9:20 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	877,303	0	877,303	14,467	60.64	30.00
31.00	INTENSIVE CARE UNIT	215,208		215,208	1,777	121.11	31.00
41.00	SUBPROVIDER - IRF	199,263	0	199,263	2,871	69.41	41.00
43.00	NURSERY	43,626		43,626	1,164	37.48	43.00
200.00	Total (lines 30 through 199)	1,335,400		1,335,400	20,279		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	970	58,821				
31.00	INTENSIVE CARE UNIT	166	20,104				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	98	3,673				
200.00	Total (lines 30 through 199)	1,234	82,598				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,031,040	41,504,697	0.024842	287,734	7,148	50.00
51.00	05100 RECOVERY ROOM	100,528	5,642,074	0.017818	58,574	1,044	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	57,199	1,057,459	0.054091	9,046	489	52.00
53.00	05300 ANESTHESIOLOGY	38,267	13,905,502	0.002752	131,295	361	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	729,354	15,090,233	0.048333	280,540	13,559	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	712,057	5,687,927	0.125187	1,889	236	55.00
56.00	05600 RADIOISOTOPE	247,019	2,341,954	0.105476	67,578	7,128	56.00
57.00	05700 CT SCAN	132,644	24,217,211	0.005477	196,650	1,077	57.00
58.00	05800 MRI	245,770	5,592,956	0.043943	58,316	2,563	58.00
59.00	05900 CARDIAC CATHETERIZATION	98,778	9,291,099	0.010631	2,060	22	59.00
60.00	06000 LABORATORY	272,351	37,034,731	0.007354	916,555	6,740	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12,632	1,225,915	0.010304	6,430	66	62.00
64.00	06400 INTRAVENOUS THERAPY	110,801	2,355,078	0.047048	82,779	3,895	64.00
65.00	06500 RESPIRATORY THERAPY	97,007	4,925,699	0.019694	320,457	6,311	65.00
66.00	06600 PHYSICAL THERAPY	72,559	2,594,332	0.027968	24,822	694	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,700	1,823,350	0.006965	3,816	27	67.00
68.00	06800 SPEECH PATHOLOGY	8,441	1,277,574	0.006607	4,034	27	68.00
69.00	06900 ELECTROCARDIOLOGY	16,571	2,832,402	0.005851	65,270	382	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	27,429	639,365	0.042900	878	38	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	149,237	106,676,998	0.001399	1,622,529	2,270	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	78,964	10,298,128	0.007668	4,820	37	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	372,702	73,317,729	0.005083	1,966,392	9,995	73.00
74.00	07400 RENAL DIALYSIS	1,731	52,275	0.033113	0	0	74.00
76.00	03950 DIABETES CENTER	2,610	17,454	0.149536	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	35,510	602,304	0.058957	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	4,371	20,252	0.215831	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	40,226	1,008,213	0.039898	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	117,622	693,877	0.169514	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	75,796	1,027,322	0.073780	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	67,801	573,746	0.118173	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	338,521	2,093,005	0.161739	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	27,691	243,476	0.113732	0	0	88.05
88.06	08806 RURAL HEALTH CLINIC VII	68,313	667,622	0.102323	0	0	88.06
88.07	08807 RURAL HEALTH CLINIC VIII	12,516	521,946	0.023979	0	0	88.07
88.08	08808 RURAL HEALTH CLINIC IX	661,370	3,979,786	0.166182	0	0	88.08
88.09	08809 RURAL HEALTH CLINIC X	27,233	616,795	0.044152	0	0	88.09
91.00	09100 EMERGENCY	463,205	21,460,082	0.021584	358,729	7,743	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	63,129	2,296,425	0.027490	53,040	1,458	92.00
200.00	Total (lines 50 through 199)	6,631,695	405,206,993		6,524,233	73,310	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-0025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/28/2020 9:20 am	
					Title XIX		Hospital		Cost	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	14,467	0.00	970	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,777	0.00	166	31.00	
41.00	04100	SUBPROVIDER - IRF	0		0	2,871	0.00	0	41.00	
43.00	04300	NURSERY			0	1,164	0.00	98	43.00	
200.00		Total (lines 30 through 199)			0	20,279		1,234	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
31.00	03100	INTENSIVE CARE UNIT		0						31.00
41.00	04100	SUBPROVIDER - IRF		0						41.00
43.00	04300	NURSERY		0						43.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:20 am
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Cost Center Description		Title XIX		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	0	88.09
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 9:20 am

			Title XIX		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	41,504,697	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,642,074	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,057,459	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,905,502	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,090,233	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	5,687,927	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,341,954	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	24,217,211	0.000000	57.00
58.00	05800	MRI	0	0	0	5,592,956	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,291,099	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	37,034,731	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,225,915	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,355,078	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,925,699	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,594,332	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,823,350	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,277,574	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,832,402	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	639,365	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	106,676,998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,298,128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73,317,729	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	52,275	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	17,454	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	602,304	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	20,252	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,008,213	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	693,877	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,027,322	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	573,746	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	2,093,005	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	243,476	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	667,622	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	521,946	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	3,979,786	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	616,795	0.000000	88.09
91.00	09100	EMERGENCY	0	0	0	21,460,082	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,296,425	0.000000	92.00
200.00	Total (lines 50 through 199)		0	0	0	405,206,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Title XIX			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	287,734	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	58,574	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	9,046	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	131,295	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	280,540	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	1,889	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	67,578	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	196,650	0	0	0	57.00
58.00	05800	MRI	0.000000	58,316	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,060	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	916,555	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	6,430	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	82,779	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	320,457	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	24,822	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,816	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,034	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	65,270	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	878	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,622,529	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,820	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,966,392	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0.000000	0	0	0	0	88.09
91.00	09100	EMERGENCY	0.000000	358,729	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	53,040	0	0	0	92.00
200.00		Total (lines 50 through 199)		6,524,233	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/28/2020 9:20 am

			Title XIX		Hospital		2/28/2020 9:20 am	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.129337	0	750,383	0	0	
51.00	05100	RECOVERY ROOM	0.389103	0	258,665	0	0	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.591175	0	3,922	0	0	
53.00	05300	ANESTHESIOLOGY	0.028398	0	391,888	0	0	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305431	0	585,185	0	0	
55.00	05500	RADIOLOGY - THERAPEUTIC	0.554514	0	228,389	0	0	
56.00	05600	RADIOISOTOPE	0.397503	0	79,958	0	0	
57.00	05700	CT SCAN	0.048463	0	584,761	0	0	
58.00	05800	MRI	0.129654	0	272,831	0	0	
59.00	05900	CARDIAC CATHETERIZATION	0.201726	0	5,300	0	0	
60.00	06000	LABORATORY	0.171687	0	1,794,943	0	0	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.635480	0	2,140	0	0	
64.00	06400	INTRAVENOUS THERAPY	0.511362	0	240,433	0	0	
65.00	06500	RESPIRATORY THERAPY	0.366996	0	51,358	0	0	
66.00	06600	PHYSICAL THERAPY	0.794858	0	330	0	0	
67.00	06700	OCCUPATIONAL THERAPY	0.446643	0	64	0	0	
68.00	06800	SPEECH PATHOLOGY	0.319686	0	1,650	0	0	
69.00	06900	ELECTROCARDIOLOGY	0.062084	0	125,454	0	0	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.571096	0	51,059	0	0	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095991	0	2,226,964	0	0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526130	0	182,069	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192579	0	2,031,138	0	0	
74.00	07400	RENAL DIALYSIS	2.498670	0	0	0	0	
76.00	03950	DIABETES CENTER	9.470322	0	241	0	0	
76.97	07697	CARDIAC REHABILITATION	0.689873	0	7,870	0	0	
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.041329	0	0	0	0	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1.095512			0	0	
88.01	08801	RURAL HEALTH CLINIC II	1.146664			0	0	
88.02	08802	RURAL HEALTH CLINIC III	1.172234			0	0	
88.03	08803	RURAL HEALTH CLINIC IV	2.221365			0	0	
88.04	08804	RURAL HEALTH CLINIC V	1.540528			0	0	
88.05	08805	RURAL HEALTH CLINIC VI	1.085175			0	0	
88.06	08806	RURAL HEALTH CLINIC VII	0.933706			0	0	
88.07	08807	RURAL HEALTH CLINIC VIII	0.609613			0	0	
88.08	08808	RURAL HEALTH CLINIC IX	2.304284			0	0	
88.09	08809	RURAL HEALTH CLINIC X	1.147427			0	0	
91.00	09100	EMERGENCY	0.302687	0	1,304,761	0	0	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.568151	0	82,978	0	0	
200.00		Subtotal (see instructions)		0	11,264,734	0	0	
201.00		Less PBP Clinic Lab. Services-Program			0	0	0	
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	11,264,734	0	0	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/28/2020 9:20 am

			Title XIX		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	97,052	0		50.00
51.00	05100	RECOVERY ROOM	100,647	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,241	0		52.00
53.00	05300	ANESTHESIOLOGY	11,129	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,734	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	126,645	0		55.00
56.00	05600	RADIOISOTOPE	31,784	0		56.00
57.00	05700	CT SCAN	28,339	0		57.00
58.00	05800	MRI	35,374	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,069	0		59.00
60.00	06000	LABORATORY	308,168	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,360	0		62.00
64.00	06400	INTRAVENOUS THERAPY	122,948	0		64.00
65.00	06500	RESPIRATORY THERAPY	18,848	0		65.00
66.00	06600	PHYSICAL THERAPY	262	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	29	0		67.00
68.00	06800	SPEECH PATHOLOGY	527	0		68.00
69.00	06900	ELECTROCARDIOLOGY	7,789	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,160	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	213,769	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,792	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	391,155	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETES CENTER	2,282	0		76.00
76.97	07697	CARDIAC REHABILITATION	5,429	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0		88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0		88.09
91.00	09100	EMERGENCY	394,934	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	47,144	0		92.00
200.00		Subtotal (see instructions)	2,256,610	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,256,610	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:

Worksheet D

Component CCN: 26-T025

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/28/2020 9:20 am

				Title XIX		Subprovider - IRF	Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,031,040	41,504,697	0.024842	0	0	50.00
51.00	05100	RECOVERY ROOM	100,528	5,642,074	0.017818	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,199	1,057,459	0.054091	0	0	52.00
53.00	05300	ANESTHESIOLOGY	38,267	13,905,502	0.002752	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	729,354	15,090,233	0.048333	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	712,057	5,687,927	0.125187	0	0	55.00
56.00	05600	RADIOISOTOPE	247,019	2,341,954	0.105476	0	0	56.00
57.00	05700	CT SCAN	132,644	24,217,211	0.005477	0	0	57.00
58.00	05800	MRI	245,770	5,592,956	0.043943	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	98,778	9,291,099	0.010631	0	0	59.00
60.00	06000	LABORATORY	272,351	37,034,731	0.007354	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,632	1,225,915	0.010304	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	110,801	2,355,078	0.047048	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,007	4,925,699	0.019694	0	0	65.00
66.00	06600	PHYSICAL THERAPY	72,559	2,594,332	0.027968	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,700	1,823,350	0.006965	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,441	1,277,574	0.006607	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16,571	2,832,402	0.005851	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,429	639,365	0.042900	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,237	106,676,998	0.001399	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,964	10,298,128	0.007668	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	372,702	73,317,729	0.005083	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,731	52,275	0.033113	0	0	74.00
76.00	03950	DIABETES CENTER	2,610	17,454	0.149536	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,510	602,304	0.058957	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,371	20,252	0.215831	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	40,226	1,008,213	0.039898	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	117,622	693,877	0.169514	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	75,796	1,027,322	0.073780	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	67,801	573,746	0.118173	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	338,521	2,093,005	0.161739	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	27,691	243,476	0.113732	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	68,313	667,622	0.102323	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	12,516	521,946	0.023979	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	661,370	3,979,786	0.166182	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	27,233	616,795	0.044152	0	0	88.09
91.00	09100	EMERGENCY	463,205	21,460,082	0.021584	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,296,425	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	6,568,566	405,206,993		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:20 am	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V		0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI		0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII		0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII		0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX		0	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X		0	0	0	0	0	88.09
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:20 am	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	41,504,697	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	5,642,074	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	1,057,459	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,905,502	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	15,090,233	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	5,687,927	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	2,341,954	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	24,217,211	0.000000	57.00
58.00	05800	MRI		0	0	0	5,592,956	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	9,291,099	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	37,034,731	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	1,225,915	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	2,355,078	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	4,925,699	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	2,594,332	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,823,350	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,277,574	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	2,832,402	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	639,365	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	106,676,998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	10,298,128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	73,317,729	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	52,275	0.000000	74.00
76.00	03950	DIABETES CENTER		0	0	0	17,454	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	602,304	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	20,252	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,008,213	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	693,877	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	1,027,322	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	573,746	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V		0	0	0	2,093,005	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI		0	0	0	243,476	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII		0	0	0	667,622	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII		0	0	0	521,946	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX		0	0	0	3,979,786	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X		0	0	0	616,795	0.000000	88.09
91.00	09100	EMERGENCY		0	0	0	21,460,082	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,296,425	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	405,206,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 9:20 am	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0.000000	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000	0	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0.000000	0	0	0	0	0	88.09
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 9:20 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,467	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,467	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		13,426	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		7,681	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,131,858	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18,131,858	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		18,131,858	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,253.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,626,828	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		9,626,828	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/28/2020 9:20 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,872,347	1,777	2,179.15	993	2,163,896	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					12,450,195	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					24,240,919	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					586,038	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					711,587	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,297,625	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,943,294	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,041	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,253.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,304,717	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/28/2020 9:20 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	877,303	18,131,858	0.048385	1,304,717	63,129	90.00
91.00 Nursing School cost	0	18,131,858	0.000000	1,304,717	0	91.00
92.00 Allied health cost	0	18,131,858	0.000000	1,304,717	0	92.00
93.00 All other Medical Education	0	18,131,858	0.000000	1,304,717	0	93.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025	Period: From 10/01/2018	Worksheet D-1	
		Component CCN: 26-T025	To 09/30/2019	Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,871	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,871	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,871	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,125	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)		3,994,688	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00	
26.00	Total swing-bed cost (see instructions)		0	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,994,688	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,994,688	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,391.39	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,956,704	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,956,704	41.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 9:20 am
		Title XVIII		Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,086,583
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,043,287
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					147,496
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					34,847
52.00 Total Program excludable cost (sum of lines 50 and 51)					182,343
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,860,944
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	199,263	3,994,688	0.049882	0	0	90.00
91.00	Nursing School cost	0	3,994,688	0.000000	0	0	91.00
92.00	Allied health cost	0	3,994,688	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,994,688	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 9:20 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,467	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,467	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		13,426	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		970	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,164	15.00
16.00	Nursery days (title V or XIX only)		98	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,131,858	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18,131,858	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		18,131,858	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,253.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,215,730	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,215,730	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 9:20 am	
Title XIX			Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	983,055	1,164	844.55	98	82,766	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	3,872,347	1,777	2,179.15	166	361,739	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,233,579	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,893,814	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					1,041	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,253.33	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,304,717	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	877,303	18,131,858	0.048385	1,304,717	63,129	90.00
91.00	Nursing School cost	0	18,131,858	0.000000	1,304,717	0	91.00
92.00	Allied health cost	0	18,131,858	0.000000	1,304,717	0	92.00
93.00	All other Medical Education	0	18,131,858	0.000000	1,304,717	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 9:20 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,749,491		30.00
31.00	03100	INTENSIVE CARE UNIT		1,043,638		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.129337	6,599,330	853,538	50.00
51.00	05100	RECOVERY ROOM	0.389103	748,760	291,345	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.591175	2,141	3,407	52.00
53.00	05300	ANESTHESIOLOGY	0.029154	2,004,860	58,450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305431	2,724,428	832,125	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.554514	22,503	12,478	55.00
56.00	05600	RADIOISOTOPE	0.397503	254,582	101,197	56.00
57.00	05700	CT SCAN	0.048463	3,421,544	165,818	57.00
58.00	05800	MRI	0.129654	396,044	51,349	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.201726	1,928,388	389,006	59.00
60.00	06000	LABORATORY	0.173058	6,969,729	1,206,167	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.635480	337,709	214,607	62.00
64.00	06400	INTRAVENOUS THERAPY	0.511362	24,953	12,760	64.00
65.00	06500	RESPIRATORY THERAPY	0.366996	2,492,842	914,863	65.00
66.00	06600	PHYSICAL THERAPY	0.794858	616,264	489,842	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.446643	216,396	96,652	67.00
68.00	06800	SPEECH PATHOLOGY	0.319686	55,746	17,821	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062084	521,130	32,354	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.571096	2,427	1,386	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095991	24,093,964	2,312,804	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526130	989,949	520,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192579	14,408,679	2,774,809	73.00
74.00	07400	RENAL DIALYSIS	2.498670	35,750	89,327	74.00
76.00	03950	DIABETES CENTER	9.470322	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.689873	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.041329	199	1,799	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000		0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000		0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000		0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0.000000		0	88.09
91.00	09100	EMERGENCY	0.302687	2,738,254	828,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.568151	310,860	176,615	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		71,917,431	12,450,195	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		71,917,431		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		1,912,500		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.129337	1,728	223	50.00
51.00	05100 RECOVERY ROOM	0.389103	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.591175	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.029154	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.305431	55,275	16,883	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.554514	0	0	55.00
56.00	05600 RADIOISOTOPE	0.397503	0	0	56.00
57.00	05700 CT SCAN	0.048463	35,065	1,699	57.00
58.00	05800 MRI	0.129654	13,330	1,728	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.201726	85	17	59.00
60.00	06000 LABORATORY	0.173058	204,435	35,379	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.635480	12,922	8,212	62.00
64.00	06400 INTRAVENOUS THERAPY	0.511362	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.366996	101,027	37,077	65.00
66.00	06600 PHYSICAL THERAPY	0.794858	760,872	604,785	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.446643	675,765	301,826	67.00
68.00	06800 SPEECH PATHOLOGY	0.319686	75,503	24,137	68.00
69.00	06900 ELECTROCARDIOLOGY	0.062084	7,345	456	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.571096	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.095991	168,484	16,173	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.526130	337	177	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.192579	178,270	34,331	73.00
74.00	07400 RENAL DIALYSIS	2.498670	1,125	2,811	74.00
76.00	03950 DIABETES CENTER	9.470322	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.689873	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	9.041329	74	669	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0.000000		0	88.05
88.06	08806 RURAL HEALTH CLINIC VII	0.000000		0	88.06
88.07	08807 RURAL HEALTH CLINIC VIII	0.000000		0	88.07
88.08	08808 RURAL HEALTH CLINIC IX	0.000000		0	88.08
88.09	08809 RURAL HEALTH CLINIC X	0.000000		0	88.09
91.00	09100 EMERGENCY	0.302687	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.568151	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,291,642	1,086,583	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,291,642		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 9:20 am	
Cost Center Description			Title XIX	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		552,906		30.00
31.00	03100	INTENSIVE CARE UNIT		160,659		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		21,353		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.129337	287,734	37,215	50.00
51.00	05100	RECOVERY ROOM	0.389103	58,574	22,791	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.591175	9,046	14,394	52.00
53.00	05300	ANESTHESIOLOGY	0.028398	131,295	3,729	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305431	280,540	85,686	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.554514	1,889	1,047	55.00
56.00	05600	RADIOISOTOPE	0.397503	67,578	26,862	56.00
57.00	05700	CT SCAN	0.048463	196,650	9,530	57.00
58.00	05800	MRI	0.129654	58,316	7,561	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.201726	2,060	416	59.00
60.00	06000	LABORATORY	0.171687	916,555	157,361	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.635480	6,430	4,086	62.00
64.00	06400	INTRAVENOUS THERAPY	0.511362	82,779	42,330	64.00
65.00	06500	RESPIRATORY THERAPY	0.366996	320,457	117,606	65.00
66.00	06600	PHYSICAL THERAPY	0.794858	24,822	19,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.446643	3,816	1,704	67.00
68.00	06800	SPEECH PATHOLOGY	0.319686	4,034	1,290	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062084	65,270	4,052	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.571096	878	501	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095991	1,622,529	155,748	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.526130	4,820	2,536	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192579	1,966,392	378,686	73.00
74.00	07400	RENAL DIALYSIS	2.498670	0	0	74.00
76.00	03950	DIABETES CENTER	9.470322	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.689873	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.041329	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.095512	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.146664	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.172234	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2.221365	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.540528	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1.085175	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.933706	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.609613	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	2.304284	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	1.147427	0	0	88.09
91.00	09100	EMERGENCY	0.302687	358,729	108,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.568151	53,040	30,135	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,524,233	1,233,579	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,524,233		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A
Date/Time Prepared:
2/28/2020 9:20 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			15,743,783	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			381,143	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			0	2.04
3.00	Managed Care Simulated Payments			222,931	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			83.15	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			5.43	30.00
31.00	Percentage of Medicaid patient days (see instructions)			13.70	31.00
32.00	Sum of lines 30 and 31			19.13	32.00
33.00	Allowable disproportionate share percentage (see instructions)			5.18	33.00
34.00	Disproportionate share adjustment (see instructions)			203,882	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0	0.000145977	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	1,175,006	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	1,175,006	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,175,006		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		17,503,814		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		20,763,146		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			20,763,146	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,289,192	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			22,052,338	59.00
60.00	Primary payer payments			4,907	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			22,047,431	61.00
62.00	Deductibles billed to program beneficiaries			2,083,228	62.00
63.00	Coinsurance billed to program beneficiaries			41,727	63.00
64.00	Allowable bad debts (see instructions)			561,098	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			364,714	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			470,490	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			20,287,190	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-46,480	70.93
70.94	HRR adjustment amount (see instructions)			-53,528	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,187,182	71.00	
71.01	Sequestration adjustment (see instructions)		403,744	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		20,050,607	72.00	
73.00	Tentative settlement (for contractor use only)		0	73.00	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-267,169	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/28/2020 9:20 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		156	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,857,157	2.00
3.00	OPPS payments		15,150,991	3.00
4.00	Outlier payment (see instructions)		441,721	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.882	5.00
6.00	Line 2 times line 5		13,986,012	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		156	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		864	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		864	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		864	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		708	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		156	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		15,592,712	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,582,762	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		13,010,106	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		13,010,106	30.00
31.00	Primary payer payments		774	31.00
32.00	Subtotal (line 30 minus line 31)		13,009,332	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		238,184	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		154,820	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		132,948	36.00
37.00	Subtotal (see instructions)		13,164,152	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-188	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		13,164,340	40.00
40.01	Sequestration adjustment (see instructions)		263,287	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		12,899,204	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1,849	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/28/2020 9:20 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		20,012,507		12,899,204	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	04/09/2019	38,100		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		38,100		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		20,050,607		12,899,204	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1,849	6.01
6.02	SETTLEMENT TO PROGRAM		267,169		0	6.02
7.00	Total Medicare program liability (see instructions)		19,783,438		12,901,053	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0025

Period:

Worksheet E-1

Component CCN: 26-T025

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/28/2020 9:20 am

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,351,783		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,351,783		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		5,184		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,356,967		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/28/2020 9:20 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part III Date/Time Prepared: 2/28/2020 9:20 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,114,039 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0316 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			30,829 3.00
4.00	Outlier Payments			321,845 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			7.865753 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,466,713 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,466,713 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,466,713 19.00
20.00	Deductibles			32,472 20.00
21.00	Subtotal (line 19 minus line 20)			3,434,241 21.00
22.00	Coinurance			8,764 22.00
23.00	Subtotal (line 21 minus line 22)			3,425,477 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,425,477 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,425,477 32.00
32.01	Sequestration adjustment (see instructions)			68,510 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			3,351,783 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			5,184 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			321,845 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/28/2020 9:20 am
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	2,893,814		1.00
2.00	Medical and other services		2,256,610	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,893,814	2,256,610	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,893,814	2,256,610	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	734,918		8.00
9.00	Ancillary service charges	6,524,233	11,264,734	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	7,259,151	11,264,734	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	7,259,151	11,264,734	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,365,337	9,008,124	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2,893,814	2,256,610	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	2,893,814	2,256,610	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,893,814	2,256,610	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,893,814	2,256,610	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,893,814	2,256,610	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2,893,814	2,256,610	40.00
41.00	Interim payments	845,849	2,611,936	41.00
42.00	Balance due provider/program (line 40 minus line 41)	2,047,965	-355,326	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/28/2020 9:20 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/28/2020 9:20 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	14,405,987	0	0	0	1.00
2.00	Temporary investments	4,026,688	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,658,883	0	0	0	4.00
5.00	Other receivable	1,708,198	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,796,510	0	0	0	7.00
8.00	Prepaid expenses	1,057,107	0	0	0	8.00
9.00	Other current assets	1,300,328	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	45,953,701	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,712,256	0	0	0	12.00
13.00	Land improvements	9,123,178	0	0	0	13.00
14.00	Accumulated depreciation	-6,700,590	0	0	0	14.00
15.00	Buildings	81,344,058	0	0	0	15.00
16.00	Accumulated depreciation	-39,671,345	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	23,083,223	0	0	0	19.00
20.00	Accumulated depreciation	-4,654,432	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	72,494,255	0	0	0	23.00
24.00	Accumulated depreciation	-54,913,749	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	3,316,339	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	87,133,193	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	57,030,983	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,434,090	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	61,465,073	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	194,551,967	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,131,061	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,913,402	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,167,661	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	826,541	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,038,665	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	43,878,569	0	0	0	47.00
48.00	Unsecured loans	2,095,440	0	0	0	48.00
49.00	Other long term liabilities	2,074,069	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	48,048,078	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	73,086,743	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	121,465,224				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	121,465,224	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	194,551,967	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/28/2020 9:20 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		119,958,814		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		185,332				2.00
3.00	Total (sum of line 1 and line 2)		120,144,146		0		3.00
4.00	FOUNDATION NET INCOME	115,538		0		0	4.00
5.00	TEMPORARILY & PERMANENTLY RESTRICTED	1,205,539		0		0	5.00
6.00	ROUNDING	1		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,321,078		0		10.00
11.00	Subtotal (line 3 plus line 10)		121,465,224		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		121,465,224		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	FOUNDATION NET INCOME		0				4.00
5.00	TEMPORARILY & PERMANENTLY RESTRICTED		0				5.00
6.00	ROUNDING		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2020 9:20 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,576,414		9,576,414	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,573,380		2,573,380	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,149,794		12,149,794	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,821,980		1,821,980	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,821,980		1,821,980	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,971,774		13,971,774	17.00
18.00	Ancillary services	146,582,743	223,441,955	370,024,698	18.00
19.00	Outpatient services	5,921,200	17,835,307	23,756,507	19.00
20.00	RURAL HEALTH CLINIC	0	1,008,213	1,008,213	20.00
20.01	RURAL HEALTH CLINIC II	0	693,877	693,877	20.01
20.02	RURAL HEALTH CLINIC III	0	1,027,322	1,027,322	20.02
20.03	RURAL HEALTH CLINIC IV	0	573,746	573,746	20.03
20.04	RURAL HEALTH CLINIC V	0	2,093,005	2,093,005	20.04
20.05	RURAL HEALTH CLINIC VI	0	243,476	243,476	20.05
20.06	RURAL HEALTH CLINIC VII	0	667,622	667,622	20.06
20.07	RURAL HEALTH CLINIC VIII	0	521,946	521,946	20.07
20.08	RURAL HEALTH CLINIC IX	0	3,979,786	3,979,786	20.08
20.09	RURAL HEALTH CLINIC X	0	616,795	616,795	20.09
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,248,636	2,248,636	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	2,847,458	10,917,929	13,765,387	27.00
27.01	PHYSICIAN REVENUE - NRCC	1,651,278	37,483,735	39,135,013	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	170,974,453	303,353,350	474,327,803	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		170,542,491		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		170,542,491		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/28/2020 9:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	474,327,803	1.00
2.00	Less contractual allowances and discounts on patients' accounts	306,468,412	2.00
3.00	Net patient revenues (line 1 minus line 2)	167,859,391	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	170,542,491	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,683,100	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	383,195	6.00
7.00	Income from investments	2,650,405	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	711,922	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	17,747	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	465,327	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAYCARE INCOME	771,605	24.00
24.01	OTHER REVENUE	1,365,761	24.01
24.02	EHR MEANINGFUL USE	68,000	24.02
25.00	Total other income (sum of lines 6-24)	6,433,962	25.00
26.00	Total (line 5 plus line 25)	3,750,862	26.00
27.00	NON-OPERATING LOSSES	3,565,530	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,565,530	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	185,332	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 26-0025

Period:

Worksheet H

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 amHome Health
Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		3,000	3,000	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	1,280	1,280	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	200,843	22,757	0	34,428	105,491	363,519
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	703,836	79,750	0	5,523	789,109	6.00
7.00	Physical Therapy	257,906	29,223	0	0	287,129	7.00
8.00	Occupational Therapy	10,479	1,187	0	0	11,666	8.00
9.00	Speech Pathology	107,908	12,227	0	3,036	123,171	9.00
10.00	Medical Social Services	3,742	424	0	0	4,166	10.00
11.00	Home Health Aide	21,884	2,480	0	0	24,364	11.00
12.00	Supplies (see instructions)	0	0	0	15,388	15,388	12.00
13.00	Drugs	0	0	0	6	6	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,306,598	148,048	0	37,464	130,688	1,622,798
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	3,000	0	3,000		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	1,280	0	1,280		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	363,519	0	363,519		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	789,109	0	789,109		6.00
7.00	Physical Therapy	0	287,129	0	287,129		7.00
8.00	Occupational Therapy	0	11,666	0	11,666		8.00
9.00	Speech Pathology	0	123,171	0	123,171		9.00
10.00	Medical Social Services	0	4,166	0	4,166		10.00
11.00	Home Health Aide	0	24,364	0	24,364		11.00
12.00	Supplies (see instructions)	0	15,388	0	15,388		12.00
13.00	Drugs	0	6	0	6		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	0	1,622,798	0	1,622,798		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 26-0025

Period:

Worksheet H-1

HHA CCN: 26-7282

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

2/28/2020 9:20 am

Home Health
Agency I

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation		
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	3,000	3,000				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	1,280	0	0	1,280		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	363,519	3,000	0	1,280	0	367,799	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	789,109	0	0	0	0	789,109	6.00
7.00	Physical Therapy	287,129	0	0	0	0	287,129	7.00
8.00	Occupational Therapy	11,666	0	0	0	0	11,666	8.00
9.00	Speech Pathology	123,171	0	0	0	0	123,171	9.00
10.00	Medical Social Services	4,166	0	0	0	0	4,166	10.00
11.00	Home Health Aide	24,364	0	0	0	0	24,364	11.00
12.00	Supplies (see instructions)	15,388	0	0	0	0	15,388	12.00
13.00	Drugs	6	0	0	0	0	6	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,622,798	3,000	0	1,280	0	1,622,798	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	367,799						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	231,262	1,020,371					6.00
7.00	Physical Therapy	84,148	371,277					7.00
8.00	Occupational Therapy	3,419	15,085					8.00
9.00	Speech Pathology	36,097	159,268					9.00
10.00	Medical Social Services	1,221	5,387					10.00
11.00	Home Health Aide	7,140	31,504					11.00
12.00	Supplies (see instructions)	4,510	19,898					12.00
13.00	Drugs	2	8					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,622,798					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 26-0025

Period:

Worksheet H-1

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/28/2020 9:20 amHome Health
Agency I

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	3,000			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	3,000	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	3,000	0	3,000	0	-367,799	1,254,999 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	789,109	6.00
7.00	Physical Therapy	0	0	0	0	287,129	7.00
8.00	Occupational Therapy	0	0	0	0	11,666	8.00
9.00	Speech Pathology	0	0	0	0	123,171	9.00
10.00	Medical Social Services	0	0	0	0	4,166	10.00
11.00	Home Health Aide	0	0	0	0	24,364	11.00
12.00	Supplies (see instructions)	0	0	0	0	15,388	12.00
13.00	Drugs	0	0	0	0	6	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,000	0	3,000	0	-367,799	1,254,999 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	3,000	0	1,280	0		367,799 25.00
26.00	Unit Cost Multiplier	1.000000	0.000000	0.426667	0.000000		0.293067 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 26-0025

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/28/2020 9:20 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	25,117	29,222	40,603	94,942	24,379	1.00
2.00	Skilled Nursing Care	1,020,371	0	0	142,291	1,162,662	298,550	2.00
3.00	Physical Therapy	371,277	0	0	52,139	423,416	108,725	3.00
4.00	Occupational Therapy	15,085	0	0	2,118	17,203	4,417	4.00
5.00	Speech Pathology	159,268	0	0	21,815	181,083	46,498	5.00
6.00	Medical Social Services	5,387	0	0	756	6,143	1,577	6.00
7.00	Home Health Aide	31,504	0	0	4,424	35,928	9,226	7.00
8.00	Supplies (see instructions)	19,898	0	0	0	19,898	5,109	8.00
9.00	Drugs	8	0	0	0	8	2	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,622,798	25,117	29,222	264,146	1,941,283	498,483	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	7,900	52,380	0	18,678	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	7,900	52,380	0	18,678	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 26-0025

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/28/2020 9:20 amHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	15.00	16.00	24.00	25.00	
1.00	Administrative and General	190,043	0	0	0	388,322	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,461,212	0	2.00
3.00	Physical Therapy	0	0	0	0	532,141	0	3.00
4.00	Occupational Therapy	0	0	0	0	21,620	0	4.00
5.00	Speech Pathology	0	0	0	0	227,581	0	5.00
6.00	Medical Social Services	0	0	0	0	7,720	0	6.00
7.00	Home Health Aide	0	0	0	0	45,154	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	25,007	0	8.00
9.00	Drugs	0	0	0	0	10	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	190,043	0	0	0	2,708,767	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	388,322						1.00
2.00	Skilled Nursing Care	1,461,212	244,531	1,705,743				2.00
3.00	Physical Therapy	532,141	89,053	621,194				3.00
4.00	Occupational Therapy	21,620	3,618	25,238				4.00
5.00	Speech Pathology	227,581	38,085	265,666				5.00
6.00	Medical Social Services	7,720	1,292	9,012				6.00
7.00	Home Health Aide	45,154	7,556	52,710				7.00
8.00	Supplies (see instructions)	25,007	4,185	29,192				8.00
9.00	Drugs	10	2	12				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	2,708,767	388,322	2,708,767				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.167348					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 26-0025

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/28/2020 9:20 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	3,000	29,222	200,843	0	94,942	3,000	1.00
2.00	Skilled Nursing Care	0	0	703,837	0	1,162,662	0	2.00
3.00	Physical Therapy	0	0	257,906	0	423,416	0	3.00
4.00	Occupational Therapy	0	0	10,479	0	17,203	0	4.00
5.00	Speech Pathology	0	0	107,908	0	181,083	0	5.00
6.00	Medical Social Services	0	0	3,742	0	6,143	0	6.00
7.00	Home Health Aide	0	0	21,884	0	35,928	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	19,898	0	8.00
9.00	Drugs	0	0	0	0	8	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,000	29,222	1,306,599		1,941,283	3,000	20.00
21.00	Total cost to be allocated	25,117	29,222	264,146		498,483	7,900	21.00
22.00	Unit cost multiplier	8.372333	1.000000	0.202163		0.256780	2.633333	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	3,000	0	3,000	0	0	37,365	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,000	0	3,000	0	0	37,365	20.00
21.00	Total cost to be allocated	52,380	0	18,678	0	0	190,043	21.00
22.00	Unit cost multiplier	17.460000	0.000000	6.226000	0.000000	0.000000	5.086123	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 26-0025

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/28/2020 9:20 amHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
		14.00	15.00	16.00		
1.00	Administrative and General	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 26-0025

Period:

Worksheet H-3

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/28/2020 9:20 am

				Title XVIII		Home Health Agency I	PPS		
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	1,705,743		1,705,743	5,168	330.06	1.00	
2.00	Physical Therapy	3.00	621,194	0	621,194	2,978	208.59	2.00	
3.00	Occupational Therapy	4.00	25,238	0	25,238	121	208.58	3.00	
4.00	Speech Pathology	5.00	265,666	0	265,666	1,246	213.22	4.00	
5.00	Medical Social Services	6.00	9,012		9,012	36	250.33	5.00	
6.00	Home Health Aide	7.00	52,710		52,710	627	84.07	6.00	
7.00	Total (sum of lines 1-6)		2,679,563	0	2,679,563	10,176		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
					Part B				
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care		99914	0	356			8.00	
8.01	Skilled Nursing Care		99926	0	2,535			8.01	
9.00	Physical Therapy		99914	0	318			9.00	
9.01	Physical Therapy		99926	0	1,697			9.01	
10.00	Occupational Therapy		99914	0	60			10.00	
10.01	Occupational Therapy		99926	0	913			10.01	
11.00	Speech Pathology		99914	0	1			11.00	
11.01	Speech Pathology		99926	0	81			11.01	
12.00	Medical Social Services		99914	0	2			12.00	
12.01	Medical Social Services		99926	0	20			12.01	
13.00	Home Health Aide		99914	0	25			13.00	
13.01	Home Health Aide		99926	0	426			13.01	
14.00	Total (sum of lines 8-13)			0	6,434			14.00	
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	29,192	0	29,192	56,803	0.513917	15.00	
16.00	Cost of Drugs	9.00	12	0	12	0	0.000000	16.00	
Cost Center Description		Program Visits			Cost of Services				
		Part B							
		Part A	Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	0	2,891		0	954,203		1.00	
2.00	Physical Therapy	0	2,015		0	420,309		2.00	
3.00	Occupational Therapy	0	973		0	202,948		3.00	
4.00	Speech Pathology	0	82		0	17,484		4.00	
5.00	Medical Social Services	0	22		0	5,507		5.00	
6.00	Home Health Aide	0	451		0	37,916		6.00	
7.00	Total (sum of lines 1-6)	0	6,434		0	1,638,367		7.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 26-0025

Period:

Worksheet H-3

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/28/2020 9:20 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	30,906	0	0	15,883	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	954,203							1.00
2.00	Physical Therapy	420,309							2.00
3.00	Occupational Therapy	202,948							3.00
4.00	Speech Pathology	17,484							4.00
5.00	Medical Social Services	5,507							5.00
6.00	Home Health Aide	37,916							6.00
7.00	Total (sum of lines 1-6)	1,638,367							7.00
Cost Center Description									
		12.00							
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 26-0025

Period:

Worksheet H-3

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/28/2020 9:20 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.794858	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.446643	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.319686	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.095991	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.192579	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025 HHA CCN: 26-7282	Period: From 10/01/2018 To 09/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	963,110	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	14,333	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	8,280	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	90,281	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	478	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,076,482	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	1,076,482	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	1,076,482	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,076,482	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	1,076,482	31.00
31.01	Sequestration adjustment (see instructions)		0	21,528	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	1,054,954	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider CCN: 26-0025

Period:

Worksheet H-5

HHA CCN: 26-7282

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 amHome Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,054,954	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,054,954	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,054,954	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/28/2020 9:20 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,272,054	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		17,138	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		42.13	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,289,192	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8512

From 10/01/2018

Date/Time Prepared:

To 09/30/2019

2/28/2020 9:20 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	224,089	0	224,089	0	224,089
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	99,030	0	99,030	0	99,030
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	135,904	0	135,904	0	135,904
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	459,023	0	459,023	0	459,023
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	12,165	12,165	0	12,165
14.00	Subtotal (sum of lines 11 through 13)	0	12,165	12,165	0	12,165
15.00	Medical Supplies	0	10,238	10,238	0	10,238
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	10,238	10,238	0	10,238
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	459,023	22,403	481,426	0	481,426
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	10,790	10,790	0	10,790
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	10,790	10,790	0	10,790
FACILITY OVERHEAD						
29.00	Facility Costs	0	7,828	7,828	0	7,828
30.00	Administrative Costs	122,457	135,609	258,066	0	258,066
31.00	Total Facility Overhead (sum of lines 29 and 30)	122,457	143,437	265,894	0	265,894
32.00	Total facility costs (sum of lines 22, 28 and 31)	581,480	176,630	758,110	0	758,110

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8512

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	224,089	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	99,030	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	135,904	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	459,023	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	12,165	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	12,165	14.00	
15.00	Medical Supplies	0	10,238	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	10,238	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	481,426	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	10,790	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	10,790	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	7,828	29.00	
30.00	Administrative Costs	0	258,066	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	265,894	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	758,110	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-3984

From 10/01/2018

Date/Time Prepared:

To 09/30/2019

2/28/2020 9:20 am

		RHC II		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	16,342	0	16,342	0	16,342
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	136,351	0	136,351	0	136,351
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	56,451	0	56,451	0	56,451
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	209,144	0	209,144	0	209,144
11.00 Physician Services Under Agreement	0	0	0	0	0
12.00 Physician Supervision Under Agreement	0	0	0	0	0
13.00 Other Costs Under Agreement	0	17,469	17,469	0	17,469
14.00 Subtotal (sum of lines 11 through 13)	0	17,469	17,469	0	17,469
15.00 Medical Supplies	0	7,352	7,352	0	7,352
16.00 Transportation (Health Care Staff)	0	0	0	0	0
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	0	0	0	0
19.00 Other Health Care Costs	0	0	0	0	0
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	7,352	7,352	0	7,352
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	209,144	24,821	233,965	0	233,965
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	13,438	13,438	0	13,438
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	0	0
25.02 Chronic Care Management	0	0	0	0	0
26.00 All other nonreimbursable costs	0	0	0	0	0
27.00 Nonallowable GME costs	0	0	0	0	0
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	13,438	13,438	0	13,438
FACILITY OVERHEAD					
29.00 Facility Costs	0	14,853	14,853	0	14,853
30.00 Administrative Costs	117,105	134,094	251,199	29,380	280,579
31.00 Total Facility Overhead (sum of lines 29 and 30)	117,105	148,947	266,052	29,380	295,432
32.00 Total facility costs (sum of lines 22, 28 and 31)	326,249	187,206	513,455	29,380	542,835

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-3984

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

				RHC II	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	16,342	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	136,351	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	56,451	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	209,144	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	17,469	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	17,469	14.00	
15.00	Medical Supplies	0	7,352	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	7,352	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	233,965	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	13,438	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	13,438	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	14,853	29.00	
30.00	Administrative Costs	0	280,579	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	295,432	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	542,835	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8513

From 10/01/2018
To 09/30/2019

Date/Time Prepared:

2/28/2020 9:20 am

		RHC III		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	108,556	0	108,556	0	108,556
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	119,730	0	119,730	0	119,730
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	118,886	0	118,886	0	118,886
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	347,172	0	347,172	0	347,172
11.00 Physician Services Under Agreement	0	0	0	0	0
12.00 Physician Supervision Under Agreement	0	0	0	0	0
13.00 Other Costs Under Agreement	0	9,893	9,893	0	9,893
14.00 Subtotal (sum of lines 11 through 13)	0	9,893	9,893	0	9,893
15.00 Medical Supplies	0	11,737	11,737	0	11,737
16.00 Transportation (Health Care Staff)	0	353	353	0	353
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	0	0	0	0
19.00 Other Health Care Costs	0	0	0	0	0
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	12,090	12,090	0	12,090
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	347,172	21,983	369,155	0	369,155
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	39,196	39,196	0	39,196
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	0	0
25.02 Chronic Care Management	0	0	0	0	0
26.00 All other nonreimbursable costs	0	0	0	0	0
27.00 Nonallowable GME costs	0	0	0	0	0
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	39,196	39,196	0	39,196
FACILITY OVERHEAD					
29.00 Facility Costs	0	2,949	2,949	0	2,949
30.00 Administrative Costs	152,923	122,812	275,735	0	275,735
31.00 Total Facility Overhead (sum of lines 29 and 30)	152,923	125,761	278,684	0	278,684
32.00 Total facility costs (sum of lines 22, 28 and 31)	500,095	186,940	687,035	0	687,035

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8513

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

				RHC III	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	108,556	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	119,730	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	118,886	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	347,172	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	9,893	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	9,893	14.00	
15.00	Medical Supplies	0	11,737	15.00	
16.00	Transportation (Health Care Staff)	0	353	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	12,090	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	369,155	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	39,196	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	39,196	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	2,949	29.00	
30.00	Administrative Costs	0	275,735	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	278,684	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	687,035	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8723

From 10/01/2018

Date/Time Prepared:

To 09/30/2019

2/28/2020 9:20 am

		RHC IV		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	537,739	0	537,739	-268,870	268,869
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	105,034	0	105,034	-52,517	52,517
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	218,320	0	218,320	-109,160	109,160
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	861,093	0	861,093	-430,547	430,546
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	40,153	40,153	0	40,153
14.00	Subtotal (sum of lines 11 through 13)	0	40,153	40,153	0	40,153
15.00	Medical Supplies	0	23,901	23,901	0	23,901
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	23,901	23,901	0	23,901
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	861,093	64,054	925,147	-430,547	494,600
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	73,199	73,199	0	73,199
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	73,199	73,199	0	73,199
FACILITY OVERHEAD						
29.00	Facility Costs	0	10,517	10,517	0	10,517
30.00	Administrative Costs	263,397	239,177	502,574	-185,618	316,956
31.00	Total Facility Overhead (sum of lines 29 and 30)	263,397	249,694	513,091	-185,618	327,473
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,124,490	386,947	1,511,437	-616,165	895,272

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8723

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC IV	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	268,869		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	52,517		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	109,160		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	430,546		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	40,153		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	40,153		14.00
15.00	Medical Supplies	0	23,901		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,901		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	494,600		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	73,199		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	73,199		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	10,517		29.00
30.00	Administrative Costs	0	316,956		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	327,473		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	895,272		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8724

From 10/01/2018
To 09/30/2019Date/Time Prepared:
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		RHC V		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	530,464	0	530,464	268,870	799,334
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	309,680	0	309,680	52,517	362,197
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	178,954	0	178,954	109,160	288,114
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	1,019,098	0	1,019,098	430,547	1,449,645
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	19,240	19,240	0	19,240
14.00	Subtotal (sum of lines 11 through 13)	0	19,240	19,240	0	19,240
15.00	Medical Supplies	0	17,660	17,660	0	17,660
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	17,660	17,660	0	17,660
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,019,098	36,900	1,055,998	430,547	1,486,545
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	8,270	8,270	0	8,270
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	8,270	8,270	0	8,270
FACILITY OVERHEAD						
29.00	Facility Costs	0	34,519	34,519	0	34,519
30.00	Administrative Costs	46,152	443,123	489,275	185,618	674,893
31.00	Total Facility Overhead (sum of lines 29 and 30)	46,152	477,642	523,794	185,618	709,412
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,065,250	522,812	1,588,062	616,165	2,204,227

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8724

From 10/01/2018
To 09/30/2019Date/Time Prepared:
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				RHC V	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	799,334	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	362,197	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	288,114	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	1,449,645	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	19,240	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	19,240	14.00	
15.00	Medical Supplies	0	17,660	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	17,660	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,486,545	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	8,270	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	8,270	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	34,519	29.00	
30.00	Administrative Costs	0	674,893	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	709,412	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,204,227	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8756

From 10/01/2018

To 09/30/2019

Date/Time Prepared:

2/28/2020 9:20 am

				RHC VI		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	48,134	0	48,134	0	48,134	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	14,634	0	14,634	0	14,634	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	37,720	0	37,720	0	37,720	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	100,488	0	100,488	0	100,488	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	2,867	2,867	0	2,867	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	2,867	2,867	0	2,867	14.00
15.00	Medical Supplies	0	2,585	2,585	0	2,585	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,585	2,585	0	2,585	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	100,488	5,452	105,940	0	105,940	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	425	425	0	425	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	425	425	0	425	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	3,239	3,239	0	3,239	29.00
30.00	Administrative Costs	3,179	41,313	44,492	0	44,492	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	3,179	44,552	47,731	0	47,731	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	103,667	50,429	154,096	0	154,096	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8756

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC VI	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	48,134		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	14,634		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	37,720		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	100,488		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	2,867		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	2,867		14.00
15.00	Medical Supplies	0	2,585		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,585		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	105,940		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	425		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	425		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	3,239		29.00
30.00	Administrative Costs	0	44,492		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	47,731		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	154,096		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8757

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

				RHC VII		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	48,134	0	48,134	0	48,134	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	90,428	0	90,428	0	90,428	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	116,883	0	116,883	0	116,883	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	255,445	0	255,445	0	255,445	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	4,850	4,850	0	4,850	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,850	4,850	0	4,850	14.00
15.00	Medical Supplies	0	3,349	3,349	0	3,349	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3,349	3,349	0	3,349	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	255,445	8,199	263,644	0	263,644	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	990	990	0	990	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	990	990	0	990	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,289	7,289	0	7,289	29.00
30.00	Administrative Costs	0	71,154	71,154	0	71,154	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	78,443	78,443	0	78,443	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	255,445	87,632	343,077	0	343,077	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8757

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC VII	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	48,134		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	90,428		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	116,883		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	255,445		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	4,850		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,850		14.00
15.00	Medical Supplies	0	3,349		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3,349		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	263,644		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	990		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	990		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	7,289		29.00
30.00	Administrative Costs	0	71,154		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	78,443		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	343,077		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8758

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		RHC VIII		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	48,134	0	48,134	0	48,134
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	74,358	0	74,358	0	74,358
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	49,422	0	49,422	0	49,422
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	171,914	0	171,914	0	171,914
11.00 Physician Services Under Agreement	0	0	0	0	0
12.00 Physician Supervision Under Agreement	0	0	0	0	0
13.00 Other Costs Under Agreement	0	1,263	1,263	0	1,263
14.00 Subtotal (sum of lines 11 through 13)	0	1,263	1,263	0	1,263
15.00 Medical Supplies	0	4	4	0	4
16.00 Transportation (Health Care Staff)	0	0	0	0	0
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	0	0	0	0
19.00 Other Health Care Costs	0	0	0	0	0
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	4	4	0	4
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	171,914	1,267	173,181	0	173,181
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	9	9	0	9
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	0	0
25.02 Chronic Care Management	0	0	0	0	0
26.00 All other nonreimbursable costs	0	0	0	0	0
27.00 Nonallowable GME costs	0	0	0	0	0
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	9	9	0	9
FACILITY OVERHEAD					
29.00 Facility Costs	0	2,808	2,808	0	2,808
30.00 Administrative Costs	62	20,040	20,102	0	20,102
31.00 Total Facility Overhead (sum of lines 29 and 30)	62	22,848	22,910	0	22,910
32.00 Total facility costs (sum of lines 22, 28 and 31)	171,976	24,124	196,100	0	196,100

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8758

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		RHC VIII		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	48,134	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	74,358	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	49,422	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	171,914	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	1,263	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,263	14.00
15.00	Medical Supplies	0	4	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	173,181	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	9	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	9	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	2,808	29.00
30.00	Administrative Costs	0	20,102	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	22,910	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	196,100	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8754

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		RHC IX		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,790,214	0	2,790,214	-1,269	2,788,945
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	321,090	0	321,090	0	321,090
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	589,228	0	589,228	0	589,228
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	3,700,532	0	3,700,532	-1,269	3,699,263
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	90	90	0	90
14.00	Subtotal (sum of lines 11 through 13)	0	90	90	0	90
15.00	Medical Supplies	0	34,720	34,720	0	34,720
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	34,720	34,720	0	34,720
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,700,532	34,810	3,735,342	-1,269	3,734,073
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	327,599	327,599	0	327,599
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	327,599	327,599	0	327,599
FACILITY OVERHEAD						
29.00	Facility Costs	0	316	316	0	316
30.00	Administrative Costs	214,845	594,541	809,386	0	809,386
31.00	Total Facility Overhead (sum of lines 29 and 30)	214,845	594,857	809,702	0	809,702
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,915,377	957,266	4,872,643	-1,269	4,871,374

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8754

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC IX	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	2,788,945		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	321,090		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	589,228		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,699,263		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	90		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	90		14.00
15.00	Medical Supplies	0	34,720		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	34,720		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,734,073		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	327,599		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	327,599		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	316		29.00
30.00	Administrative Costs	0	809,386		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	809,702		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,871,374		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8759

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		RHC X		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	78,235	78,235
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	139,920	0	139,920	0	139,920
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	93,024	0	93,024	0	93,024
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	232,944	0	232,944	78,235	311,179
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	3,082	3,082	0	3,082
14.00	Subtotal (sum of lines 11 through 13)	0	3,082	3,082	0	3,082
15.00	Medical Supplies	0	6,662	6,662	0	6,662
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	6,662	6,662	0	6,662
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	232,944	9,744	242,688	78,235	320,923
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	2,661	2,661	0	2,661
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,661	2,661	0	2,661
FACILITY OVERHEAD						
29.00	Facility Costs	0	162	162	0	162
30.00	Administrative Costs	64,867	75,253	140,120	0	140,120
31.00	Total Facility Overhead (sum of lines 29 and 30)	64,867	75,415	140,282	0	140,282
32.00	Total facility costs (sum of lines 22, 28 and 31)	297,811	87,820	385,631	78,235	463,866

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8759

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		RHC X		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	78,235	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	139,920	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	93,024	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	311,179	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	3,082	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	3,082	14.00
15.00	Medical Supplies	0	6,662	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,662	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	320,923	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	2,661	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,661	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	162	29.00
30.00	Administrative Costs	0	140,120	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	140,282	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	463,866	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8512

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.86	1,964	4,200	3,612		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.01	2,848	2,100	2,121		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.87	4,812		5,733	5,733	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.87	4,812			5,733	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					481,426	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					10,790	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					492,216	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.978079	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					265,894	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					346,399	15.00
16.00	Total overhead (sum of lines 14 and 15)					612,293	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					612,293	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					598,871	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,080,297	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-3984

From 10/01/2018
To 09/30/2019

Date/Time Prepared:

2/28/2020 9:20 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.06	106	4,200	252		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	2,626	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.06	2,732		2,352	2,732	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.06	2,732			2,732	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					233,965	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,438	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					247,403	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.945684	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					295,432	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					252,809	15.00
16.00	Total overhead (sum of lines 14 and 15)					548,241	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					548,241	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					518,463	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					752,428	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8513

From 10/01/2018
To 09/30/2019Date/Time Prepared:
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				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.47	1,556	4,200	1,974		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.03	2,690	2,100	2,163		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.50	4,246		4,137	4,246	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.50	4,246			4,246	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					369,155	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					39,196	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					408,351	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.904014	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					278,684	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					517,227	15.00
16.00	Total overhead (sum of lines 14 and 15)					795,911	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					795,911	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					719,515	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,088,670	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8723

From 10/01/2018
To 09/30/2019

Date/Time Prepared:

2/28/2020 9:20 am

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.00	3,287	4,200	4,200		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.50	1,655	2,100	1,050		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.50	4,942		5,250	5,250	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.50	4,942			5,250	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					494,600	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					73,199	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					567,799	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.871083	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					327,473	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					379,227	15.00
16.00	Total overhead (sum of lines 14 and 15)					706,700	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					706,700	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					615,594	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,110,194	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8724

From 10/01/2018
To 09/30/2019

Date/Time Prepared:

2/28/2020 9:20 am

				RHC V		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.91	3,705	4,200	12,222		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.76	8,270	2,100	7,896		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.67	11,975		20,118	20,118	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.67	11,975			20,118	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,486,545	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					8,270	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,494,815	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.994468	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					709,412	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,020,105	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,729,517	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,729,517	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,719,949	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,206,494	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8756

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

				RHC VI		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.30	639	4,200	1,260		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.15	427	2,100	315		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.45	1,066		1,575	1,575	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.45	1,066			1,575	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					105,940	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					425	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					106,365	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996004	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					47,731	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					110,118	15.00
16.00	Total overhead (sum of lines 14 and 15)					157,849	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					157,849	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					157,218	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					263,158	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8757

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		RHC VII		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.20	730	4,200	840
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	1.01	2,485	2,100	2,121
4.00	Subtotal (sum of lines 1 through 3)	1.21	3,215	2,961	3,215
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.21	3,215		3,215
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				263,644
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				990
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				264,634
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.996259
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				78,443
15.00	Parent provider overhead allocated to facility (see instructions)				280,286
16.00	Total overhead (sum of lines 14 and 15)				358,729
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				358,729
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				357,387
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				621,031

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8758

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 9:20 am

		RHC VIII		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.20	684	4,200	840
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.76	1,744	2,100	1,596
4.00	Subtotal (sum of lines 1 through 3)	0.96	2,428		2,436
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.96	2,428		2,436
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				173,181
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				9
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				173,190
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.999948
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				22,910
15.00	Parent provider overhead allocated to facility (see instructions)				122,085
16.00	Total overhead (sum of lines 14 and 15)				144,995
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				144,995
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				144,987
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				318,168

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8754

From 10/01/2018
To 09/30/2019

Date/Time Prepared:

2/28/2020 9:20 am

				RHC IX		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	10.41	16,635	4,200	43,722		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.70	2,738	2,100	5,670		3.00
4.00	Subtotal (sum of lines 1 through 3)	13.11	19,373		49,392	49,392	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	13.11	19,373			49,392	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,734,073	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					327,599	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,061,672	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.919344	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					809,702	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,299,183	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,108,885	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,108,885	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,696,823	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,430,896	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 26-0025 Component CCN: 26-8759		Period: From 10/01/2018 To 09/30/2019		Worksheet M-2 Date/Time Prepared: 2/28/2020 9:20 am	
			RHC X		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4			
	1.00	2.00	3.00	4.00	5.00			
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	0.01	7	4,200	42			1.00
2.00	Physician Assistant	0.00	0	2,100	0			2.00
3.00	Nurse Practitioner	1.06	4,357	2,100	2,226			3.00
4.00	Subtotal (sum of lines 1 through 3)	1.07	4,364		2,268	4,364		4.00
5.00	Visiting Nurse	0.00	0			0		5.00
6.00	Clinical Psychologist	0.00	0			0		6.00
7.00	Clinical Social Worker	0.00	0			0		7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0		7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0		7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.07	4,364			4,364		8.00
9.00	Physician Services Under Agreements		0			0		9.00
							1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES								
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)						320,923	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						2,661	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						323,584	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0.991776	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						140,282	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						243,861	15.00
16.00	Total overhead (sum of lines 14 and 15)						384,143	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						384,143	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						380,984	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						701,907	20.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN: 26-8512		Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,080,297	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			24,145	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,056,152	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,733	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,733	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			184.22	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,235	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	104,605	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	104,605	16.00
16.01	Total program charges (see instructions)(from contractor's records)			199,590	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			1,151	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			603	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			68,904	16.04
16.05	Total program cost (see instructions)		0	69,507	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17,872	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			36,113	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			69,507	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			13,080	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			82,587	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			82,587	26.00
26.01	Sequestration adjustment (see instructions)			1,652	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			66,533	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			14,402	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025 Component CCN: 26-3984	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			752,428	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			43,966	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			708,462	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,732	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,732	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			259.32	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	770	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	65,219	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	65,219	16.00
16.01	Total program charges (see instructions)(from contractor's records)			137,649	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			343	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			163	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			42,126	16.04
16.05	Total program cost (see instructions)		0	42,289	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			12,399	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			24,981	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			42,289	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			26,054	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			68,343	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			68,343	26.00
26.01	Sequestration adjustment (see instructions)			1,367	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			40,103	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			26,873	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/28/2020 9:20 am		
		Title XVIII	RHC III	Cost		
			1.00			
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,088,670	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			91,427	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			997,243	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,246	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			4,246	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			234.87	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			83.45	84.70	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	1,285	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	108,840	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	108,840	16.00
16.01	Total program charges (see instructions)(from contractor's records)				216,851	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				875	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				439	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				73,788	16.04
16.05	Total program cost (see instructions)			0	74,227	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				16,166	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				39,962	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				74,227	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				41,247	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				115,474	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				115,474	26.00
26.01	Sequestration adjustment (see instructions)				2,309	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				71,207	27.00
28.00	Tentative settlement (for contractor use only)				0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)				41,958	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN: 26-8723		Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC IV	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,110,194	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			47,837	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,062,357	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,250	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,250	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			202.35	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,634	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	138,400	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	138,400	16.00
16.01	Total program charges (see instructions)(from contractor's records)			258,283	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			375	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			201	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			89,256	16.04
16.05	Total program cost (see instructions)		0	89,457	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			26,629	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			46,256	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			89,457	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			35,852	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			125,309	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			125,309	26.00
26.01	Sequestration adjustment (see instructions)			2,506	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			85,199	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			37,604	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3		
		Component CCN: 26-8724		Date/Time Prepared: 2/28/2020 9:20 am		
		Title XVIII	RHC V	Cost		
			1.00			
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,206,494	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			73,754	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,132,740	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,118	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			20,118	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			155.72	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			83.45	84.70	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	2,081	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	176,261	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	176,261	16.00
16.01	Total program charges (see instructions)(from contractor's records)				335,175	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				365	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				192	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				114,688	16.04
16.05	Total program cost (see instructions)			0	114,880	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				32,709	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				60,420	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				114,880	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				34,194	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				149,074	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				149,074	26.00
26.01	Sequestration adjustment (see instructions)				2,981	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				109,476	27.00
28.00	Tentative settlement (for contractor use only)				0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)				36,617	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025 Component CCN: 26-8756	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/28/2020 9:20 am		
		Title XVIII	RHC VI	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			263,158	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			261	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			262,897	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,575	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			1,575	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			166.92	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			83.45	84.70	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	258	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	21,853	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	21,853	16.00
16.01	Total program charges (see instructions)(from contractor's records)				60,452	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				15,071	16.04
16.05	Total program cost (see instructions)			0	15,071	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				3,014	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				11,488	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				15,071	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				15,071	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				15,071	26.00
26.01	Sequestration adjustment (see instructions)				301	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				14,473	27.00
28.00	Tentative settlement (for contractor use only)				0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)				297	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN: 26-8757		Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC VII	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			621,031	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			1,048	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			619,983	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,215	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,215	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			192.84	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,099	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	93,085	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	93,085	16.00
16.01	Total program charges (see instructions)(from contractor's records)			249,223	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,742	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			1,024	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			56,772	16.04
16.05	Total program cost (see instructions)		0	57,796	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			21,096	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			45,077	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			57,796	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			57,796	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			57,796	26.00
26.01	Sequestration adjustment (see instructions)			1,156	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			54,385	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			2,255	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN: 26-8758		Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC VIII	Cost	
			1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			318,168	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			3,450	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			314,718	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,436	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,436	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			129.19	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	499	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	42,265	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	42,265	16.00
16.01	Total program charges (see instructions)(from contractor's records)			109,353	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			623	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			241	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			27,772	16.04
16.05	Total program cost (see instructions)		0	28,013	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			7,309	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			20,284	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			28,013	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			28,013	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			28,013	26.00
26.01	Sequestration adjustment (see instructions)			560	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			26,710	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			743	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN: 26-8754		Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC IX	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			8,430,896	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			458,809	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			7,972,087	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			49,392	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			49,392	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			161.40	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	4,269	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	361,584	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	361,584	16.00
16.01	Total program charges (see instructions)(from contractor's records)			764,352	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			485	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			230	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			252,321	16.04
16.05	Total program cost (see instructions)		0	252,551	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			45,953	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			143,583	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			252,551	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			70,073	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			322,624	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			322,624	26.00
26.01	Sequestration adjustment (see instructions)			6,452	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			242,635	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			73,537	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2018	Worksheet M-3	
		Component CCN: 26-8759	To 09/30/2019	Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC X	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			701,907	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			17,132	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			684,775	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,364	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,364	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			156.91	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	291	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	24,648	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	24,648	16.00
16.01	Total program charges (see instructions)(from contractor's records)			38,453	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			13,496	16.04
16.05	Total program cost (see instructions)		0	13,496	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			7,778	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			6,135	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			13,496	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			5,951	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			19,447	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			19,447	26.00
26.01	Sequestration adjustment (see instructions)			389	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			12,596	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			6,462	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8512	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		459,023	459,023	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000643	0.007027	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		295	3,226	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2,398	4,841	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		2,693	8,067	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		481,426	481,426	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		598,871	598,871	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.005594	0.016756	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		3,350	10,035	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		6,043	18,102	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		15	164	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		402.87	110.38	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		10	82	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		4,029	9,051	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			24,145	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			13,080	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-3984	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		209,144	209,144	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001739	0.016100	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		364	3,367	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,725	6,215	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,089	9,582	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		233,965	233,965	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		518,463	518,463	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.017477	0.040955	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		9,061	21,234	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		13,150	30,816	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		23	213	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		571.74	144.68	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		19	105	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		10,863	15,191	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			43,966	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			26,054	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		347,172	347,172	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.005075	0.017200	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,762	5,971	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		12,348	10,921	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		14,110	16,892	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		369,155	369,155	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		719,515	719,515	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.038222	0.045759	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		27,501	32,924	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		41,611	49,816	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		95	322	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		438.01	154.71	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		26	193	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		11,388	29,859	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			91,427	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			41,247	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8723	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC IV	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		430,546	430,546	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002885	0.014476	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,242	6,233	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		7,318	6,519	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		8,560	12,752	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		494,600	494,600	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		615,594	615,594	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.017307	0.025782	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		10,654	15,871	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		19,214	28,623	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		54	271	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		355.81	105.62	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		50	171	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		17,791	18,061	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			47,837	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			35,852	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8724	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC V	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,449,645	1,449,645	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001297	0.004985	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,880	7,226	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		16,906	8,181	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		18,786	15,407	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,486,545	1,486,545	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,719,949	1,719,949	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.012637	0.010364	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		21,735	17,826	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		40,521	33,233	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		108	415	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		375.19	80.08	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		54	174	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		20,260	13,934	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			73,754	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			34,194	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8756	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC VI	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		100,488	100,488	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000356	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	36	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	69	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	105	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		105,940	105,940	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		157,218	157,218	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.000991	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	156	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	261	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	2	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	130.50	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			261	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8757	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC VII	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		255,445	255,445	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000066	0.000464	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		17	119	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		105	204	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		122	323	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		263,644	263,644	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		357,387	357,387	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000463	0.001225	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		165	438	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		287	761	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		1	7	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		287.00	108.71	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			1,048	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8758	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC VIII	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		171,914	171,914	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000584	0.001002	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		100	172	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,342	264	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,442	436	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		173,181	173,181	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		144,987	144,987	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008327	0.002518	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,207	365	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,649	801	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		7	12	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		378.43	66.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			3,450	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8754	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC IX	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		3,699,263	3,699,263	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.004492	0.010329	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		16,617	38,210	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		122,178	26,203	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		138,795	64,413	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,734,073	3,734,073	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,696,823	4,696,823	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.037170	0.017250	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		174,581	81,020	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		313,376	145,433	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		735	1,690	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		426.36	86.06	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		104	299	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		44,341	25,732	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			458,809	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			70,073	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8759	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 9:20 am	
		Title XVIII	RHC X	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		311,179	311,179	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000300	0.013180	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		93	4,101	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		542	3,097	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		635	7,198	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		320,923	320,923	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		380,984	380,984	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001979	0.022429	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		754	8,545	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		1,389	15,743	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		4	176	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		347.25	89.45	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		4	51	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,389	4,562	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			17,132	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			5,951	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8512	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		66,533	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		66,533	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		14,402	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		80,935	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-3984	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		40,103	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		40,103	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		26,873	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		66,976	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am	
			RHC III	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		71,207	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		71,207		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		41,958		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		113,165		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8723	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC IV	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		85,199	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		85,199	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		37,604	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		122,803	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8724	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC V	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		109,476	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		109,476	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		36,617	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		146,093	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8756	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am
		RHC VI	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		14,473	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		14,473	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		297	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		14,770	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8757	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC VII	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		54,385	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		54,385	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		2,255	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		56,640	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8758	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC VIII	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		26,710	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		26,710	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		743	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		27,453	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8754	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am	
		RHC IX	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		242,635	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		242,635		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		73,537		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		316,172		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 26-0025 Component CCN: 26-8759	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 9:20 am	
			RHC X	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		12,596	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		12,596	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		6,462	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		19,058	7.00	
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00